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# TEARS OF THE MESENTERY

ANTHONY V. MIGLIACCIO, M.D., AND J. ROBERT BOWEN, M.D.

The Authors. *Anthony V. Migliaccio, M.D., Surgeon, Department of Surgery, and J. Robert Bowen, Assistant Surgeon, Department of Surgery, Rhode Island Hospital.*

THIS PAPER deals with a specific type of intra-abdominal pathology, occasionally seen after non-penetrating abdominal injuries of varying severity. There has been a notable paucity of literature dealing with the subject, and it is deemed worthwhile to report six cases, together with a discussion of the major features of the entity, since it seems to us that certain of these injuries may be overlooked in the early phase when treatment is most successfully carried out.

Sudden increase in the intra-abdominal pressure due to a crushing injury can cause many bizarre clinical pictures. One which is not too common and which can be easily overlooked, is that caused by a tear in the mesentery of the bowel.

The hemorrhage from the tear in the mesentery may be moderate or severe, depending upon the size of the involved vessels. The resulting clinical picture will vary accordingly. With extreme hemorrhage, the usual signs of shock and collapse are quite readily recognized after the injury. The abdomen is filled with blood and immediate and energetic replacement therapy is indicated. Where the injury is minimal, considerable clinical judgment will be required, as one can obtain either a hematoma in the mesentery or bleeding into the free peritoneal cavity and the indications for laparotomy may not be as obvious. Bleeding from small mesenteric vessels may be slow and steady, so that the signs of shock appear late in the clinical course and often without warning. Because of this, one may miss the opportune time for adequate therapy.[1] As a late complication, the thrombosis of vessels, particularly venous channels, resulting from hemorrhage into the leaves of the mesentery, may cause infarction of the bowel wall. Long tears may so impede the blood supply to the bowel that gangrene is inevitable. The length of the tear to bring about this picture is not definite, but according to Gordon-Taylor,[2] a three-quarter inch tear along the mesenteric border of the bowel will suffice. Frazer[3] feels, from clinical experience, that three to four inches of small bowel may be devascularized without ensuing gangrene and that even a greater length of colon may be denuded of its blood supply without ill effects.

The important thing in these cases, is to recognize the injury and to choose the optimum time for surgery, as it is necessary to explore the abdomen and stop the bleeding as soon as possible after the initial shock has been completely or partially corrected. Once the pressure has risen and then shown a secondary drop, the opportunity of salvaging the individual is probably lost, in the majority of cases.

A review of the literature on non-penetrating injuries of the abdomen fails to yield any substantial material on tears of the mesentery, as few of the writers present any cases, while most of them merely mention it as a possibility. The type of force which is necessary to produce this injury is one of increased intra-abdominal pressure. As pressure is exerted on the abdominal wall, there results a diminution in the size of the abdominal cavity, resulting in abnormal motion of the mobile bowel, with sudden arrest by fixed portions. The usual locations, in order of frequency, are, at the junction of the terminal ileum with the cecum, at the junction of the descending colon and sigmoid, at the gastroduodenal junction and, lastly, at the duodeno-jejunal junction. One unusual case of a tear of the mesentery of a Meckel's diverticulum was reported by Edward S. Lowe.[4]

Clarkson[5] has classified various types of traumatic force resulting in intra-abdominal injuries as follows:

1. Compression
2. Traction
3. Disruption force where there is increased intra-luminal pressure with rupture of the bowel wall.

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Estes[6] has classified non-penetrating intra-abdominal injuries into—:

1. Severe multiple injuries, which are rapidly fatal and no therapy is of avail.
2. Injuries requiring immediate operations.
3. Injuries where the diagnosis is doubtful and the indications for or against operation are doubtful.

We believe that all mesenteric tears result from traction force, the causative mechanism being varied and relatively unimportant.

The incidence of mesenteric tears has never been cited, that we could find. Totten[7] points out the fact that eleven out of the twelve cases of laceration of the mesentery seen at the Hospital of the University of Southern California resulted from automobile accidents. Only seven of the twelve were unattended by perforation of the bowel. One of the seven was operated upon and survived. The remaining six, in all of whom other injuries were present, died. Operation was not performed "because of diagnostic errors in three and the moribund condition of the patient in the other three." The underlying cause of death in these six cases was hemorrhage and attendant shock.

The history is usually one of severe compression injury of the abdomen, whatever the cause. The symptoms on admission vary according to the severity of the injury. If the hemorrhage has been profuse, the patient will be admitted to the hospital in severe shock with attendant cold, clammy skin, rapid, thready pulse, restlessness and low blood pressure. The blood count, in the early stages, does not accurately reflect the degree of hemorrhage. If one delays intervention, he will be astonished at the rapidity with which the count drops. In those cases in which bleeding occurs at a slower rate, the drop in the red cell count will be slower and will give a truer picture of the condition of the patient. A varying leucocytosis is to be expected but is not of any diagnostic significance in the first hours following surgery. After the initial shock, there is an improvement in the clinical picture, the blood pressure and the pulse. This is deceiving, as it is due to nature's attempt to equilibrate the blood volume in relation to the intravascular space by means of peripheral vasoconstriction. If something is not done at this point, then one may find that a secondary shock again intervenes and this is of dire significance, as the physiological mechanisms of vasoconstriction employed to combat shock have reached their maximum with a large loss of blood volume. Patterson and Bromberg[8] and Beecher[9] emphasize the fact that, "if a blood pressure of 85 mm. of mercury or above can be maintained, together with signs of subsiding vasoconstriction, such as warm skin and slowing pulse rate, the operation may proceed. If the patient fails to respond to the shock treatment after the administration of two to four pints of whole blood, there must be continued intra-peritoneal bleeding, and the decision to operate requires all the surgical judgment one can muster. In spite of the poor clinical condition, surgical intervention will be the only method of salvaging some of these patients." Careful examination of the abdomen usually fails to reveal any signs of external injury.

### *Pain*

Pain is a constant finding, but varies in degree. With considerable intra-abdominal hemorrhage, shoulder pain, due to diaphragmatic irritation, may be present. In our six cases, all constantly complained of pain. In four, it was generalized. In the remaining two, the pain was localized to the site of injury. Shoulder pain was not present in any of these cases, even though three had massive quantities of blood in the peritoneal cavity.

### *Tenderness and Rigidity*

Tenderness and rigidity are present, although, in the early stages, one may not be able to elicit either. Frequently, the point of tenderness may be a guide as to the location of the injury. Using Totten's classification, we found the following:

Five cases with generalized rigidity.
No cases with local rigidity only.
One case without rigidity.

Two of our five cases with generalized rigidity were beginning to localize their rigidity while the replacement therapy was underway. It is our belief that temporizing for localization is very dangerous.

### *Vomiting*

This may or may not be present, but if present and persistent, it is indicative of a severe abdominal injury. This was not present in any of our cases. Moynihan, (as quoted from Totten[7]) stated that "vomiting, with a continuous increase of pulse rate after the period of shock is over, were two signs together which justify exploration."

### *Shifting Dullness*

With extreme hemorrhage, this may be present and is due to a large volume of blood in the peritoneal cavity, but we were unable to find it in the peritoneal cavity in any of our cases. Gatch[10] states that probably two quarts of blood in the peritoneal cavity is the smallest quantity that will give physical signs.

### *Temperature, Pulse and Blood Pressure*

On admission, a weak and thready pulse, associated with a low temperature and blood pressure, is to be expected, if profound shock is present. An increase in temperature, due to absorption of breakdown of hemoglobin may occur, but this is

a late sign. The pulse rate can be expected to rise in direct proportion to the amount of hemorrhage, whereas the blood pressure will fall.

### *Duration of Injury Before Operation*

This has a direct bearing on the mortality rate, as has been intimated before.

### *Treatment*

Energetic replacement of the lost blood is essential, together with early surgical intervention. The longer the delay in operating, the higher the mortality rate. Four of our six cases were operated upon within four hours from the time of injury and the other two within eleven hours. The administration of oxygen may be necessary. If, in spite of adequate replacement therapy, the shock persists, the patient should be brought to the operating room and intra-arterial transfusions and surgery should be performed simultaneously. The operative procedure will vary with the findings. Simple ligature of the bleeding vessels may suffice. On other occasions, suture of the rent in the mesentery may be necessary and, in those patients with long tears, resection and anastomosis will be indicated.

### *Rhode Island Hospital Experience*

Our experience at the Rhode Island Hospital during the last fifteen years consists of only six cases. Curiously, five of these six cases were encountered by one of us (A.V.M.). These cases represent every type of tear of the mesentery obtainable.

I. *Tears of the Gastro-hepatic Omentum.* Mr. A. L. Admitted November 5, 1946. About one hour before admission, this patient was struck in the abdomen by a piece of wood. This piece of wood had flown out of a wood saw.

Physical Examination: The patient was well nourished, well developed, oriented and complaining of abdominal pain. Blood pressure was 115/65, temperature 100, pulse 84, and respirations 22. His abdomen presented a slightly elevated and contused area in the left lower quadrant. There was generalized spasm and tenderness. The remainder of the examination was essentially normal.

Laboratory Examination: A flat plate of the abdomen was not remarkable. Hemoglobin 13.9, red blood count 4.16 million, white blood count 20,000 with 74% polys., 17% lymphocytes and 9% monocytes. Urinalysis showed a specific gravity of 1.020, negative protein, negative sugar and negative sediment. Stool for guaiac was negative.

Hospital Course: Shortly after admission, the patient was taken to the operating room and explored through a left rectus incision. A large blood clot filled the area between the liver and the stomach. When the clot was removed, two small arteries were seen bleeding in the gastro-hepatic omentum close to the stomach. These were clamped and tied. The tear in the gastro-hepatic omentum admitted two fingers and this was closed with interrupted sutures. A huge hemorrhagic area extended over the entire right half of the pancreas and a hematoma was also seen subserosally in the jejunum for a distance of one inch. The wound was closed in layers. The patient received a total of 1500 cc. of blood during his hospital stay. His postoperative course was uneventful.

II. *Tears of the Gastro-colic Ligament, Associated with a Tear of the Mesentery of the Small Bowel.* Mr. R. O. Admitted January 26, 1939. While working on a truck, the patient was caught between the tailboard and platform, crushing his abdomen. He was brought to the Rhode Island Hospital one hour following his accident.

Physical Examination: The patient was a well-developed boy, rational and cooperative. Blood pressure was 90/60, temperature 100.1 and pulse 110. His abdomen showed generalized tenderness with spasm of both rectus muscles. Rebound tenderness was present. The remainder of the examination was essentially normal.

Laboratory Examination: A flat plate of the abdomen on admission was not remarkable. Urinalysis showed a specific gravity of 1.015, negative protein, negative sugar, and sediment was normal. White blood count was 17,100 with 86% polys and 14% lymphocytes. Blood urea nitrogen was 11 and blood glucose was 93.

Hospital Course: The patient was taken to the operating room shortly after admission and a right rectus incision made. The peritoneal cavity contained free blood. A laceration was found in the gastro-colic mesentery and another bleeding laceration located in the small bowel mesentery. An extensive retroperitoneal hematoma was also present. The bleeding vessels in the gastro-colic ligament and small bowel mesentery were tied and the wound closed in layers without drainage. A resection was not necessary. The patient received a total of 1350 cc. of blood during his stay. The wound healed primarily and the patient's course was uneventful.

III. *Tears of the Mesentery of the Mid-ileum with Rupture of a Soft Tuberculous Gland.* Mr. T. M. Admitted March 19, 1945. This patient was caught momentarily between two trucks with his abdomen receiving the major trauma. On admission, he complained of pain in his right lower abdomen.

Physical Examination: The patient was a well-developed, well-nourished male, twenty-six years of age, lying in bed with moderate abdominal pain. Blood pressure was 110/62, temperature 100, pulse

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106 and respirations 32. The entire abdomen was spastic with the greatest amount of spasm and pain being present in the right lower quadrant. Only infrequent peristaltic sounds were heard. Rectal was negative. The remainder of the examination was essentially normal, with the exception of large bilateral inguinal herniae.

Laboratory Examination: A chest roentgenogram showed no evidence of fractured ribs. Hemoglobin was 15.7, red blood count 5.03 million. Urinalysis showed a specific gravity of 1.025, negative protein and sugar and normal sediment. Guaiac test was negative. Culture and smear with guinea pig inoculation of a mesentric gland were negative for tuberculosis. Pathological report of the mesenteric gland revealed the wall of a degenerated gland—probably healed tuberculosis.

Hospital Course: The patient was taken to the operating room and a right rectus incision made. A large amount of blood with clots was removed from the peritoneal cavity. Exploration revealed a tear in the mesentery of the distal ileum extending from the root of the mesentery to the bowel. Eight inches proximal to this tear, there was a smaller tear, extending halfway down the mesentery from the bowel. The bleeding vessels were clamped and tied. Approximately one inch from the root of the mesentery in the region of the larger tear, there was a large eggshell-like structure, apparently the calcified outer coat of a tuberculous gland which had ruptured. The contents of this gland were strewn throughout the peritoneal cavity and had to be removed by sponging. The shell of the gland was excised and the mesentery sutured. The patient's wound healed by first intention and his postoperative course was uneventful.

IV. *Tears of the Mesentery of the Terminal Ileum, Associated with a Rupture of the Bladder, Fracture and Dislocation of the Sacro-iliac Joint.* Mr. R. M. Admitted February 17, 1939. While at work, a 300-pound roll of wire fell on this patient's abdomen with a crushing force. On admission to the hospital, the patient was in shock and no further history was obtainable.

Physical Examination: Blood pressure was 80/40, temperature 98.6, rectally, pulse 100 and respirations 20. This twenty-six-year-old patient's entire abdomen was spastic with general tenderness. Peristalsis was absent. A sausage-shaped swelling was present lateral to the right rectus muscle, extending over the right flank. The remainder of the examination was not remarkable.

Laboratory Examination: A flat plate of the abdomen on admission was not remarkable. Roentgenograms of the pelvis showed a comminuted fracture of the right ileum with separation of the pubic bones at the symphysis. Hemoglobin was 72%. Red blood count 3.2 million. White blood count was 7,700 with 22% lymphocytes. Urinalysis showed a specific gravity of 1.030, negative protein and sugar and normal sediment. Blood urea nitrogen was 17 and blood glucose 111.

Hospital Course: The patient was taken to the operating room shortly after admission and a right rectus incision made. Hemorrhage under the external oblique fascia was found and blood was seen oozing out of the external ring. The bladder wall was edematous and discolored with intramural hemorrhage. Free blood was present in the peritoneal cavity. Exploration revealed a tear in the mesentery of the ileum. Its bleeding vessels were tied and about nine inches of bowel was resected and a lateral anastomosis done. The bladder tear sutured, patient's course was uneventful. He remained in the hospital for treatment of his fractured pelvis and was discharged two months later.

V. *Tears of the Mesentery of the Sigmoid.* Mr. J. K. Admitted December 27, 1941. About three hours before admission, this patient was caught between a moving freight car and a building. The car pinned him against the building across his pelvis. The patient's past history revealed that, two months before admission, he had had an exploration of his right kidney for question of an aberrant vessel. Tissue about the pelvis was removed.

Physical Examination: The patient was a well-developed, twenty-nine-year-old male, lying in bed with moderate abdominal pain. Blood pressure was 122/72, temperature 100, pulse 72 and respirations 20. His abdomen showed generalized spasm with marked right lower quadrant tenderness. The remainder of the examination was essentially normal.

Laboratory Examination: Admission roentgenogram showed fractures of the left and right pubic bones without separation. A flat plate of the abdomen was essentially normal. The urinalysis showed a specific gravity of 1.020, negative sugar and negative protein. Sediment was normal. White blood count was 12,000 with 88% polys and 12% lymphocytes.

Hospital Course: Shortly after admission, the patient was taken to the operating room and a right rectus incision made. Free blood was not encountered. A small tear was present in the mesentery of the sigmoid (one and one-half centimeters in length) which was closed. The appendix was removed, and the wound closed in layers. Sutures were removed seven days later and the patient was transferred to the Fracture Service.

VI. *Tears of the Mesentery of the Terminal Ileum, Associated with Concomitant Tear of the Mesentery at the Junction of the Descending Colon and Sigmoid.* Mr. E. M. Admitted March 12, 1939. Shortly before admission, this patient was crushed

against his truck by another truck, the tailboard of which pressed against his abdomen.

Physical Examination: The patient was a well-developed, well-nourished, thirty-seven-year-old male, lying in bed with moist skin, oriented and co-operative. His blood pressure was 85/40, temperature 97, pulse 100 and respirations 18. His abdomen was soft with only a suggestive tenderness on deep palpation in the right upper quadrant. The remainder of the examination was essentially normal.

Laboratory Examination: Roentgenograms of the chest and abdomen were not remarkable. Urinalysis was normal.

Hospital Course: Twelve hours after admission, the patient developed acute abdominal signs and was taken to the operating room. A right rectus incision was made. Free blood was present beneath the greater omentum. The mesentery of the terminal eighteen inches of the ileum was torn, and a resection of this portion of the ileum was done. The distal ileum was so short that an ileocolostomy was performed. Further exploration revealed the sigmoid to be gangrenous in its midportion and its mesentery was likewise torn. Because of the precarious condition of the patient, this portion of the sigmoid was exteriorized through a left lower quadrant incision. The patient's condition continued downhill and he expired the following day.

### *Results*

Only one patient died, giving us a mortality rate of 16%. This death, (Case number 6) was due to a delay in making the correct diagnosis. The patient showed an excellent response of his body mechanism to blood loss. It was so excellent that we were lulled into a false sense of security by the rise in blood pressure, the drop in pulse and the disappearance of his signs of shock for a period of several hours. A secondary shock then supervened and the opportune moment had vanished.

## SUMMARY AND CONCLUSIONS

1. Blunt trauma to the abdomen because of sudden severe intra-abdominal compression may present no external evidence of injury, whereas the abdominal cavity may have been subjected to many types of severe injury. Among these are tears of the mesentery.
2. A brief survey of the clinical findings has been presented, along with the reports of six cases encountered in the Rhode Island Hospital within the last ten years.
3. We have emphasized the difficulty in making the diagnosis in many of these patients.
4. We have also emphasized the necessity for prompt replacement therapy and the need for early surgical intervention.
5. It is much wiser to look and see when there is any suspicion, as waiting may be fatal, whereas a laparotomy should cause only a temporary inconvenience to the patient if nothing is found.

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## EXCERPTA MEDICA

**First Ether Operation. October 17th, 1846**

**178.**

**Dr. Morton, Tremont Row.**

**Dear Sir,**

**I write at the request of Dr. J. C. Warren to invite you to be present on Friday morning at 10 o'clock, at the hospital, to administer to a patient who is then to be operated upon the preparation which you have invented to deminish the sensibility to pain.**

**Yours respectfully,**

**C. F. HEYWOOD.**

**House Surgeon to the General Hospital, Massachusetts.**

**October 14th, 1846.**

**179.**

**On October 17th the patient being prepared for the operation, the apparatus was applied to his mouth by Dr. Morton for about three minutes, at the end of which time he sank into a state of insensibility. I immediately made an incision about three inches long through the skin of the neck, and began a dissection among important nerves and blood-vessels without any expression of pain on the part of the patient. Soon after he began to speak incoherently, and appeared to be in an agitated state during the remainder of the operation. Being asked immediately afterwards whether he had suffered much, he said he had felt as if his neck had been scratched; but subsequently, when inquired of by me, his statement was that he did not experience pain at the time, although aware that the operation was proceeding.**

**J. C. WARREN (1778-1856)**

# MAJOR ISSUES IN THE PROPOSED COVERAGE OF PHYSICIANS UNDER SOCIAL SECURITY*

BENJAMIN B. KENDRICK

The Author. *Benjamin B. Kendrick, of New York, New York. Research Associate, Life Insurance Association of America; formerly Social Security Analyst, United States Chamber of Commerce, and Editor, AMERICAN ECONOMIC SECURITY; formerly, Chief of Program Coordination, Social Security Board, Bureau of Old Age and Survivors Insurance.*

IT IS A pleasure to be in Providence, and to have the opportunity of discussing the proposed coverage of physicians under social security with the members of the Providence Medical Association. I hope I can be of some assistance to you by pointing up what I believe are the major issues to be considered.

### *Importance of Issue*

This coverage question is quite an important one. If physicians should be brought under the old-age and survivors insurance provisions of the social security legislation—the so-called OASI system—a beginning doctor could anticipate paying social security taxes of up to about $10,000 in the course of a lifetime of practice—and this figure is based on the unlikely assumption that the OASI system will not be further liberalized during his lifetime. When possible liberalizations in the system are taken into account, the physician's lifetime taxes might run a great deal higher. Roughly offsetting these taxes, of course, are the social security benefit expectancies he would gain.

More important than the dollars and cents of it may be some other questions involved. For instance, would the medical professon be able to speak more effectively in Washington on matters relating to social security, if inside or outside the OASI system? Again, is there any right or wrong to the coverage proposal from a standpoint of principle?

Because of the importance of the issues, it is good that the medical profession is devoting increasing attention to the proposal for social security coverage. Let me say, too, that if doctors should decide to seek OASI coverage, they had better be very sure they have reached the right decision—because once under the OASI system, it is most unlikely they would ever have a chance to withdraw.

### *The Physicians Must Decide*

It is of course the responsibility of Congress, in its wisdom, to enact and amend the Federal social security laws. However, Congress has never yet extended OASI coverage to any considerable group of people without evidence that the members of the group preponderantly wanted to be under OASI. If spokesmen for the medical profession should tell Congress that doctors want OASI coverage, they would surely acquire it shortly thereafter. Conversely, if medical spokesmen continue to tell Congress that doctors do not want OASI coverage, then I have no doubt that physicians can remain outside the system—at least for some time to come.

Thus, it seems to me, doctors must decide for themselves whether they want to be in or out of OASI. It would certainly be presumptuous of me—or of any other layman—to try to tell the members of the medical profession what they ought to do. What I may be able to contribute tonight is to furnish some relevant information, and some informed guesses, that may assist those present in arriving at their own conclusions.

### *Voluntary OASI Coverage for Physicians Unlikely*

In advance of this meeting, Mr. Farrell thoughtfully sent me a copy of the May 1955 report on the Rhode Island Medical Society's membership poll as to physician participation in the OASI system. As you know, the report showed that, while the vast majority of the members responding were opposed to compulsory OASI coverage, voluntary coverage for those wishing it was favored by a good majority.

However, there are a number of objections to voluntary OASI coverage for doctors—or for any other group—and I think Congress is well aware of them. The chief argument against voluntary coverage concerns the so-called *adverse selection* involved. In other words, the thought is that those whose prospective benefits stood to be greater than their prospective taxes would tend to

*An address delivered at the 110th Annual Meeting of the Providence Medical Association, at Providence, Rhode Island, January 7, 1957.

choose to be in the system, whereas those whose taxes stood to exceed their benefits would tend to stay out. To the extent these tendencies operated, the voluntary participants would make a *profit* on their coverage. Moreover, assuming the system continues to be run on a self-supporting basis, any profit made by voluntary participants must necessarily be at the long-run expense of the others under OASI, who are almost all covered on a compulsory basis.

Another objection to voluntary coverage relates to what most people agree on as being the system's fundamental purpose—that of furnishing a basic floor of protection for all against want. The argument runs that, under voluntary provisions, those most likely to need the benefits would be the least likely to elect coverage, whereas those least likely to be in need would be the most likely to elect coverage. Perhaps this argument is not entirely applicable to physicians, but certainly there is at least some merit in it.

A third argument is that a governmental program like OASI, dealing with tens of millions of people over scores of years, must be kept relatively simple if it is not to bog down through administrative complexities and costs in sheer bureaucratic weight. And voluntary provisions do mean a great deal of extra complexity that I perhaps need not take the time to spell out.

For these reasons, it seems unlikely that Congress would offer physicians, on an individual basis, the right to accept or reject OASI coverage. I think the actual choice will prove to be between no coverage for any and compulsory coverage for all.

### *Employed Physicians Already Covered*

In saying "no coverage for any," I am of course referring to self-employed physicians. Doctors employed on a salary, as no doubt you know, are now covered by OASI (and have been since the system's inception), if the employment area itself is inside the system's purview.

Perhaps you are not aware of the extent to which physicians already have OASI coverage. I have some figures on this, based on a sample survey made by the OASI Bureau of the Social Security Administration in 1955.

According to that survey, 45 per cent of the 201,000 physicians listed in the A.M.A. directory had at least some credited earnings under OASI. And 22 per cent of the physicians listed had enough OASI coverage to have a so-called *fully insured* status under the system or to have had such a status at some previous time.

The sample survey, also, studied separately the listed physicians who were in self-employment (presumably private practice in most cases) at the time the survey was made. Such physicians, of course, could have asquired OASI wage credits either before entering private practice or by part-time employment while in private practice. At any rate, of the self-employed physicians, 35 per cent had at least some covered earnings, while 11 per cent had or had had a *fully insured* status.

These figures have probably gone up somewhat since the survey was made. The main reason for thinking so is that there have been several bits of new legislation since then, extending the area of OASI coverage, and hencè increasing the proportion of salaried physicians who are covered.

In this regard, let me call your attention to some new legislation extending regular OASI coverage, beginning January 1, 1957, to members of the armed forces. There are also gratuitous OASI wage credits provided for military service between September 15, 1940, and December 31, 1956. Both sets of provisions are fully applicable to service in the uniformed forces in any medical capacity.

I know personally of one case where these provisions have already proven effective. There is a lady employed in our office whose husband had been a physician before his death about two years ago. He had never been under the regular OASI provisions, had never paid a cent in social security taxes, and in fact, did not even have a social security number. However, he had served for about four years in the armed forces during the war. As a result, his widow and four children together have been drawing $66.40 a month in OASI benefits.

The general point I am trying to make is that physicians have a surprisingly large amount of OASI coverage already. The proposal we are discussing can hence be restated as being whether doctors wish OASI coverage for private practice to go with the coverage they already have in salaried employment and during periods of military service.

### *How Would Doctors Make Out Compared With Others Under OASI?*

Let me now turn to the question of whether doctors would get their money's worth out of the OASI system if they were covered under it. This question can best be handled as two separate questions: First, how would doctors make out compared with the general population under OASI? And second, how does the covered population, on an average, make out under OASI? These questions, let me emphasize, relate to compulsory coverage; I have already suggested that physicians would stand to get a good deal more than their money's worth out of the system if they were to have coverage on an optional basis.

No mathematical answer is possible to either of the two questions on compulsory coverage. This

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is mainly because OASI does not stand still; no one really knows what the system will come to be like in the future. However, I think the questions on how doctors would make out can be answered fairly well—but in non-mathematical terms.

Compared with other people compulsorily covered by OASI, doctors would be better off in one major way, and worse off in another. Doctors would be better off than most others in that, as self-employed persons, they would pay only three-quarters of the combined employer-employee taxes applying to people in covered employment. At the ultimate tax rates, applicable in 1975 and thereafter under the present tax-rate schedule, the self-employed will pay 6⅜ per cent in contrast with a combined 8½ per cent on employment earnings.

On the other hand, the OASI benefit formula is geared to favor those at the low end of the earnings' scale. Because physicians tend to be near the high end of the scale, this means that the benefit formula is geared to their disadvantage. But the 25 per cent discount that doctors would get on their tax bill may roughly cancel the fact that the benefit formula would be loaded against them.

There are various other minor points about how physicians would fare under OASI, compared with others under the system, of which perhaps only one is worth mentioning. I have frequently heard it argued that doctors would lose out because they do not normally retire at age sixty-five but continue their practices indefinitely. Hence, it is argued, physicians could not draw OASI retirement benefits because the so-called *work clause* would operate to prevent it.

In my best judgment, there is little real substance to this argument. For one thing, most laymen likewise do not retire at age sixty-five. The statistics show that, so far, the average age at retirement under OASI has been about sixty-nine. Moreover, there is a provision in the OASI legislation that the so-called *work clause* ceases to apply at age seventy-two. And it is not at all far-fetched to think that Congress may reduce this age at which benefits become payable regardless of earnings to seventy.

So, all things considered, I think doctors would make out about as well under compulsory OASI coverage as do people generally.

### *How Do People Generally Make Out Under OASI?*

But does the covered population generally get its money's worth from OASI? On the whole, I think so—but I am speaking now only about the existing system, and not about what it may come to be in the future.

In any event, the aggregate of benefit payments under the system does not differ greatly from the aggregate of tax receipts. Some of the past tax receipts have been used to build up a relatively small reserve fund, which is still increasing slowly. This fund earns interest, which adds to the amounts available for benefits. On the other hand, administrative expenses are paid out of the fund. Concerning administrative expenses, I may say that the OASI program is a huge, mass-production type of operation, and as a result, the administrative costs run only about 2 per cent of the sums taken in or paid out.

In contrast to an insurance company, OASI pays no taxes and employs no salesmen. On the other hand, the interest earnings of OASI are quite small, relatively speaking. This is mainly because the system has operated on nearly a pay-as-you-go basis, and consequently, the reserve fund represents only a small fraction of the accrued liabilities. Also, the funds are invested in Government bonds, which bear a relatively low interest rate.

Of course, there is much more to it than these brief comments indicate. An insurance company guarantees its policy benefits; OASI benefits, on the other hand, are subject to change—or even discontinuance—at the will of Congress, as Section 1104 of the amended Social Security Act explicitly provides. Also, loans can be had against insurance-policy reserves; in OASI there are no loan provisions.

More important, insurance companies offer numerous policies from which the purchaser can carefully select the one best meeting his needs, desires, and premium-paying ability. In OASI, by contrast, there is no choice: One set of benefit and tax provisions applies, willy-nilly, to all.

Perhaps this last point is the heart of the matter. As a social benefit program, designed to meet the minimum needs for protection of the population generally, OASI can be considered a *good buy*, with the participants, on the whole, truly getting their money's worth. However, if OASI should be over-expanded, and attempt to provide full protection for the population, then participants will no longer be getting their money's worth because their taxes will be buying benefits differing, more or less, from what they need, want, and are willing to pay for. And no misfit article, that you are required to use, can be a good buy regardless of the price.

### *Questions of Principle and Philosophy*

More important than the dollars and cents of doctors' coverage under OASI may be questions of principle or philosophy, as I suggested earlier. The trouble is that some people—using one line of argument—arrive at the conclusion physicians certainly should be covered, while others—using

another line of argument—conclude that they certainly should not be.

People such as some of my former colleagues at the Social Security Board argue that OASI is designed to furnish universal protection, that the system cannot work with maximum efficiency so long as any important group remains outside it, and that consequently physicians should be brought under the general law. My own feeling is that, while there is some validity to this argument, universal coverage is not really essential. Also, I think it is proper—and in accord with democratic principles—for Congress to take the wishes of the group affected into account.

The opposing view, briefly, is that social security is a step on the road to socialism and worse—and that the medical profession should consequently oppose coverage with vigor. My own feeling is that, while future history might verify the first part of this argument, the second part does not follow. In other words, if broad forces are leading the United States to socialism, the trend could hardly be affected much by the action of physicians on OASI coverage.

All in all, I am personally not convinced that there are over-riding considerations of philosophy or principle either way. Consequently, if I were a physician, I think I would view the question mainly from an economic standpoint, making the best guess I could as to what changes in OASI the future is likely to bring.

### *Future Changes in OASI*

And that leads us to the $64 billion question—how will OASI be shaped in the future? Will the system be over-expanded?

It could happen. Surely Congress will be subject to continual pressure for OASI liberalization—higher benefits, more lenient eligibility requirements, new types of benefits. And it can scarcely be doubted that some liberalizations will be enacted from time to time.

Nevertheless, I am cautiously optimistic that the pressure for continual OASI expansion can be contained fairly well within reasonable bounds. The chief thing that makes me think so is the growing evidence that the repeatedly increased OASI payroll taxes are beginning to become high enough and painful enough to encourage voters to carefully scrutinize all proposals to expand benefits.

During consideration of the bill which became the 1956 Social Security Amendments, Congressmen seemed very conscious of the tax angle. The original bill had provided full benefits for women at age sixty-two, instead of sixty-five, but this provision in conjunction with the new cash disability benefit provisions would have cost employers and employees a tax increase of one per cent of payroll. To avoid such a tax increase, reduced benefits for wives and working women below sixty-five were substituted, with the tax increase being held to one-half of one per cent.

Moreover, it is important to remember that existing law provides a whole schedule of tax increases to take effect between now and 1975. And these tax increases, of course, are required merely to meet the growing costs of the present benefit provisions—they cannot be used to provide additional benefits. When the American people have had to meet the first one or two of these scheduled tax increases, with no corresponding increase in benefits, they will be even less willing than at present to pay still higher taxes for new liberalizations in the benefit provisions.

### *Possible OASI Liberalizations Affecting Medical Practice*

What possible liberalizations in OASI would affect the practice of medicine? Let me devote just a minute or two to this question.

To begin with, as you know, the new cash disability benefit provisions in the 1956 Amendments do affect medical practice. The doctor's role is to make examinations and certifications as to apparently disabling impairments, subject to some supervision from the social security authorities.

There will surely be intense pressure for expansion of these new provisions. Under present legislation, the benefits are available only at age fifty and over, but demands are already heard that they be provided regardless of age.

Moreover, there are no benefits for the wives and children of disability beneficiaries under the new provisions, whereas dependents' benefits are provided under OASI in case of retirement or death. Dependents' benefits in disability cases are sure to be urged.

Also, the 1956 Amendments provide benefits for disabled children. You see, there are two separate things: Benefits for the able-bodied dependents of disabled people, and benefits for the disabled dependents of people who are dead or retired, but not disabled. In any event, the new principle of benefits for disabled dependents could conceivably be carried much further.

Now as to the possibilities for Federal medical-care benefits—that is, socialized medicine—either inside or outside the OASI system. It seems clear that the direct threat of such legislation has largely evaporated. And I think much of the credit is due to the phenomenal growth of voluntary health insurance—both in numbers covered and in the breadth and depth of their protection. Here I think the insurance companies—along with Blue Cross and Blue Shield——are entitled to take a bow.

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# RHEUMATIC CARDITIS IN LATE ADULT LIFE

ANTHONY CAPUTI, M.D.

The Author. *Anthony Caputi, M.D., of Newport, Rhode Island. Senior Physician and Cardiologist, Department of Medicine, Newport Hospital.*

THE CLINICIAN is aware of the variable features of rheumatic carditis and is not surprised to find rheumatic valvulitis in adults who deny a background of rheumatic fever. Rheumatic fever is frequently seen in early adult life, and recent cardiac surgery has reaffirmed the presence of rheumatic carditis in all age groups.

The following three case reports in patients, 54, 64 and 70 years of age, reaffirm the possibility of underlying rheumatic carditis in later life. Early diagnosis may be important in consideration of therapy, penicillin prophylaxis and rest. The cases also reveal some of the diagnostic problems that exist in determining the presence of underlying rheumatic heart disease.

### *Case I*

This fifty-four-year-old sculptor had a twelve-year history of auricular fibrillation with cardiomegaly and a five-year history of taking digitalis with a more recent (two-year) history of quinidine intake. There had never been any evidence of congestive failure or angina pectoris. Rheumatic fever background was unknown. The only pertinent factor was a history of influenza in 1918 which was nearly fatal, and a hospitalization in August 1955, for ventricular tachycardia (? inactive rheumatic heart disease).

Physical examination in the asymptomatic state revealed auricular fibrillation, marked cardiomegaly and a blowing non-transmitted grade II apical systolic murmur; the blood pressure was 140/70. The electrocardiogram revealed auricular fibrillation, a ventricular rate of 80 and nonspecific ST-T segment changes consistent with digitalis effect. The chest roentgenogram revealed nonspecific cardiac enlargement. It was concluded that rheumatic heart disease was a possibility.

On February 22, 1956, the patient was hospitalized with an episode of acute ventricular tachycardia. Treatment consisted of intramuscular quinidine (0.6 Gm.) in two doses followed by intravenous pronestyl (750mg.) with continuous electrocardiographic control. The patient expired suddenly within twelve hours of admission probably from cardiac standstill or ventricular fibrillation.

Autopsy studies revealed a heart weighing 806 Gm., and two thickened mitral valve cusps containing verrucous nodularities with similar vegetations on one aortic cusp. Microscopic sections through these areas revealed acute and subacute vegetative lesions containing fibrinoid exudate and acute and chronic inflammatory cells. This exudate was also present throughout the myocardium and pericardium. There was also a small organized posterior myocardial infarction with 75 per cent atherosclerotic reduction in the lumen of the coronary artery. The cause of death was rheumatic pancarditis.

### *Case II*

A seventy-year-old male had minimal hypertension for years, and initially noticed shortness of breath with unconsciousness for about two years prior to hospitalization on January 29, 1951. At that time he was treated for an acute bout of pulmonary edema. The patient was admitted to the Newport Hospital on February 19, 1953, with pulmonary edema and angina. There had never been any history of rheumatic fever.

There was an established diagnosis of rheumatic heart disease with aortic stenosis and marked cardiomegaly. The E.C.G. revealed right bundle branch block and the chest X ray revealed moderate cardiomegaly, a mild left pleural effusion and generalized patchy pneumonitis involving the hilar regions predominantly. On February 23, 1953, a pericardial friction rub developed and on February 28, 1953, the patient died suddenly. An underlying myocardial infarction was suspected but not confirmed by electrocardiography.

The post-mortem findings revealed a heart weighing 750 Gm. The mitral valve cusps were thickened and the aortic valve was bony, rigid and calcified. The pericardium was thickened with fibrinous exudate. The coronary vessels were moderately occluded, particularly the left anterior descending artery. Microscopic examination revealed that the epicardium was infiltrated with neutrophiles and fibrinoid exudate was extensive.

There were stellate scars throughout the myocardium containing many chronic inflammatory cells.

The cause of death was aortic stenosis and acute fibrinous pericarditis. There was acceptable evidence for the presence of rheumatic myocarditis. Coronary atherosclerosis was an additional finding.

### *Case III*

This sixty-four-year-old white male was found to have a heart murmur during a routine physical examination in 1937. During January 1955, he was hospitalized with a recent history of pulmonary edema due to rheumatic heart disease with mitral stenosis. The admission on April 23, 1955, was due to rapidly advancing congestive heart failure. There was no history of rheumatic fever.

The physical examination revealed findings of left and right sided failure. The B.P. was 120/65 and the heart was markedly enlarged. There was bigeminal rhythm; there was a harsh presystolic and grade III systolic murmur at the apex with transmission into the axilla. A harsh thrill was palpable in this area. $M_1$ was obliterated by this murmur. The chest X ray revealed moderate cardiomegaly, pulmonary edema at the bases and fluid in each pleural cavity. The electrocardiogram revealed fibrillation, multifocal premature systoles and nonspecific ST-T segment changes consistent with digitalis effect. The patient died on May 3, 1955, following a sudden episode of chest pain. Acute myocardial infarction was considered a possibility.

The post-mortem examination revealed a heart weighing 470 Gm. The epicardial surface was soft and granular. The right auricle and ventricle were dilated to twice the usual capacity and the mitral valve cusps were thickened with scarred, shortened chordae tendineae, and a dilated mitral ring. Microscopic examination revealed a thickened pericardium containing large infiltrates of neutrophiles, lymphocytes, plasma cells and histiocytes. On the innermost surface there were large areas of fibrinoid exudate with Aschoff granulomata and neutrophiles. The myocardium contained numerous stellate scars containing peripheral Aschoff granulomata. The endocardium was thickened and there was moderate sclerosis.

The cause of death was ascribed to rheumatic pancarditis.

### *Discussion*

Jones[1] has listed the major and minor manifestations of rheumatic fever. Many cases, particularly in childhood, will present manifestations necessary to establish the diagnosis of rheumatic fever. Likewise, carditis in its full-blown picture leaves little doubt in diagnosis particularly if Jones's criteria are present. The presence of newly developing murmurs which vary, and the development of a protodiastolic gallop rhythm supported by roentgenographic signs of cardiac dilatation leave little doubt as to the diagnosis. When these findings are supported by electrocardiographic evidence, then the clinician is surely on safe ground for a diagnosis of rheumatic carditis.

Grifone and Kitchell[2] have emphasized the obscurity of rheumatic activation in later adult life. This is not difficult to understand, when other types of cardiac disease may mask the presence of activity. Rheumatic heart disease itself may be the camouflaging agent. Inflammatory reactions of many types in older life may smoulder and not become clinically manifest. Decker et al[3] further report rheumatic activity as evidenced by rheumatic nodules in auricular appendages in 45% of patients who undergo mitral valvulotomy.

White[4] in his translation of Aschoff's work describes the typical lesion of rheumatic heart involvement as inflammation with acute and chronic cell forms in association with multinucleated giant cells and centrally placed fibrinoid necrosis. Other aspects of the pathology are, however, verrucous endocarditis involving the valve edges and pericarditis. While the Aschoff granulomata are diagnostic of carditis, collections of chronic inflammatory cells in association with other stigmata of rheumatic heart disease are often enough evidence for the diagnosis. The sedimentation rate[5] may be normal in rheumatic activity associated with congestive heart failure. The acute phase reactants are positive in all acute inflammatory disease. The O-antistreptolysin may be negative in smoldering rheumatic fever.

It is certainly clear that the pathological and clinical laboratory criteria of rheumatic activity are not always adequate for diagnosis. McCarty[6] has stated that there is a threshold level of inflammation below which current laboratory tests are non-recording. The diagnosis of rheumatic fever or carditis may be impossible in certain cases.

## CONCLUSIONS AND SUMMARY

Three cases of rheumatic carditis in the older age group are presented to reaffirm the necessity of considering underlying rheumatic carditis in bizarre manifestations of heart disease, but especially to emphasize that underlying atherosclerotic or inactive rheumatic heart disease itself may confuse the clinical picture. Electrocardiograms may not help in the diagnosis because of camouflaging or nonspecific patterns. Tachycardia and cardiomegaly may be due to old cardiac pathology and not active carditis.

It is important to consider underlying active rheumatic carditis in all types of active or suspected heart disease. Diagnosis may be difficult,

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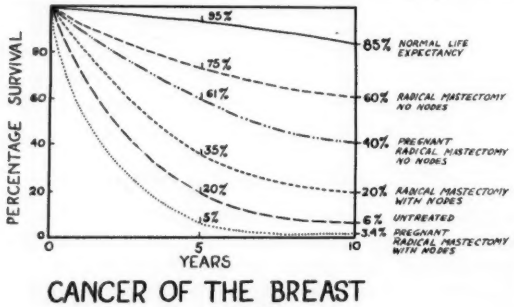
# BREAST CARCINOMA ASSOCIATED WITH PREGNANCY OR LACTATION*

J. MERRILL GIBSON, JR., M.D.

The Author. *J. Merrill Gibson, Jr., M.D. Senior Resident in Surgery, Rhode Island Hospital, Providence, Rhode Island.*

THE ASSOCIATION of breast carcinoma and pregnancy or lactation is perilous but not hopeless. Surgical opinion on this subject is varied and conflicting due mainly to the small number of patients seen by any one surgeon or clinic. Statistical studies are often misleading because of the many factors involved. Only one thing is clear, and that is that no set of rules can be formulated which can be applied to all patients.

Breast carcinoma and pregnancy are not commonly associated. Two per cent of breast carcinomas are complicated by pregnancy. The obstetricians' chances of seeing carcinoma in pregnancy are very small, in fact, about one in 10,000. However, when he does find one, he will delay treatment one month longer than the average physician with a similar case in a non-pregnant woman. The pregnant patient will delay reporting carcinomatous lumps in the breast to her physician two months longer than the average non-pregnant patient. The chances of a five-year survival in these patients




CANCER OF THE BREAST
**FIGURE 1**

is poor. In the largest reported series, by White,[7] who collected cases from all over the world, the five-year survival rate was 17% and the ten-year survival rate was 11%. These figures are certainly discouraging, but if one studies the problem more closely by subdividing the groups, the outlook for certain patients becomes much more favorable.

The graph (Fig. 1) is taken from Ackerman and Regato[1] and shows the over-all outlook for all patients with carcinoma of the breast who are not pregnant. I have taken a rough approximation of Harrington's[4] figures and patients with carcinoma of the breast complicated by pregnancy or lactation and superimposed them on the chart. It is obvious that patients who are pregnant or lactating do not do as well as others. But when looking at the chart one must remember that aside from pregnancy, these series are not comparable. The average age of Harrington's[4] patients is 36.6 years and although I do not know the average age of the patients in Ackerman's[1] series, the average age for all breast carcinomas is 45-55 years. Numerous reports have shown that the prognosis is poor in younger women. Westberg[6] has compared groups of pregnant and non-pregnant women with cancer of the breast and found that the results were only slightly poorer in the pregnant group. There are some individual reports from some of the larger clinics which offer a more optimistic view than White's[7] over-all survival of 17%. Adair,[2] from Memorial Hospital, reports 45% five-year survival in 102 patients. In Harrington's[4] group of those pregnant at the time of surgery and with no axillary nodes, the ten-year survival is 67%. However, if the patient was lactating at the time of surgery, the ten-year survival was only 33%.

The reasons for unfavorable results in pregnancy are multiple. There is a large amount of clinical and experimental work demonstrating the cancer-stimulating effect of estrogens. This is undoubtedly a potent factor. The increased activity and vascularity of the breast during pregnancy, and especially during lactation must also be considered as favoring metastasis. The difficulty in diagnosis due to engorgement of the breast complicates the problem. The younger age of the patients, as mentioned earlier, is another factor. The confusion with breast abscess, especially in lactating women, must also be considered, particularly since most breast abscesses are found in lactating women. Harrington[4] has shown that the grade of malignancy is higher in pregnancy.

*Presented at the Second Surgical Friday Conference, at the Rhode Island Hospital, at Providence, Rhode Island, November, 1956.

None of his patients had Grade I lesions. Even more important is the incidence of axillary node metastasis. In the Mayo Clinic series 64% of breast carcinomas were found to have axillary node metastases, whereas the incidence was 85% in breast carcinomas associated with pregnancy.

The treatment of cancer of the breast in pregnancy is far from uniform, but opinions are becoming less conflicting than they were a decade ago. Haagensen and Stout,[3] in their classical article on criteria for operability of breast carcinomas in 1943, stated categorically that operation on pregnant or lactating females was futile. They have since modified their opinion on this point. Adair[2] disagrees with Haagensen's[3] point of view on inoperability as illustrated by the following quotation. "We consider any case operable in which the disease is localized in the breast or breast and axilla, and in which we consider there is a chance of cure, no matter how small that chance." In a disease with an untreated mortality of 100%, a 1% survival is an individual saved. Harrington[4] has said: "We assume a great responsibility when we advise a patient to undergo radical mastectomy; we assume an even greater responsibility when we refuse to perform one."

The basic recommended treatment for carcinoma of the breast in pregnancy is quite uniform today and does not differ from that in nonpregnant women, that is, biopsy and radical mastectomy. The points of divergence of opinion are, when to perform the operation, whether the pregnancy should be terminated, and the subject of castration. During the first and second trimesters most surgeons agree that radical surgery should be carried out at once. Spontaneous abortion will occur in about 5% of these patients. During the third trimester the question arises as to whether one should withhold surgery until the baby is born, either by normal process or by Caesarean section to accelerate the process, or to operate immediately and not consider the pregnancy. According to Westberg,[6] "It is unsuitable to delay the surgical treatment even for a week or two." According to Lewison,[5] ". . . The individual patient merits particular attention. The ardent parental longing for a viable child should take preference over all other considerations." There is no question that delay adds to the risk and lowers the survival rate, but I think there is also an individual, moral, ethical, and religious question. The surgical problem is clear.

Should the pregnancy be interrupted at all times? The answer to this question is even more difficult. Adair[2] showed that the five-year survivals were almost doubled when the pregnancy was terminated immediately. Cheek sent questionnaires to 55 well-known surgeons, and the majority agreed that pregnancy should be immediately terminated. Harrington[4] and Westberg[6] do not offer a definite opinion on the subject. White[7] states that abortion cannot be shown to improve results. I can add no more than to quote Killgore's statement concerning advisability of pregnancy after radical mastectomy. "Even the most favorable case has less than 100% chance of freedom from recurrence. The chances of living out a normal life span are substantially less than normal. The child who loses his mother loses his most priceless birthright." Concerning the subject of pregnancy after a radical mastectomy, most authors have shown that the five-year survivals of this unique group is greater than that for those who do not become pregnant. This, however, is a selected group because those with more advanced disease don't live long enough to become pregnant, are advised not to become pregnant, or are treated by some method that makes pregnancy unlikely or impossible. The subject of castration can be answered only by saying that the indications are the same as for any group of premenopausal patients with carcinoma of the breast.

During the last ten years, seven patients have been treated at the Rhode Island Hospital for carcinoma of the breast in pregnancy. The average age was 34 years. All were white. All but two had axillary metastasis, an incidence of 70%. The average delay prior to surgery was three months. One patient was operated upon just three months ago. Of the remaining six, only one patient is known to be alive; nine years and four months following surgery, with no evidence of recurrence. One patient was alive and well four years after surgery with no evidence of recurrence, but has since become lost to follow-up. The three-year survival rate was 66%. The five-year survival rate was 40%; and the nine-year survival rate 20%. The correct diagnosis was made clinically in only two of the cases. No axillary nodes were palpable in any of the patients. The case histories are of interest and illustrate the confusion and indecision which characterize the treatment of these patients with carcinoma of the breast in pregnancy.

### *Case Reports*

1. D. S., 499005. This thirty-three-year-old female entered the hospital in July, 1952, in her seventh month of pregnancy, having noted a mass four weeks prior to admission. This was her second pregnancy. On examination, the lateral half of her breast was indurated and tender, and a clinical diagnosis of breast abscess was made. Biopsy disclosed adenocarcinoma and five days later, a radical mastectomy was performed. The final pathologic diagnosis was adenocarcinoma of the breast with axillary metastases. The baby was delivered by section one week after discharge, as an emergency

*continued on next page*

procedure, when fetal heart sounds suddenly disappeared. An oophorectomy was performed at the same time. The child was stillborn. The patient was immediately placed on testosterone. Patient was given X-ray therapy to the axillary and supraclavicular area, but died in September, 1953, fourteen months after surgery.

2. M. M., 484708. This thirty-seven-year-old female entered this hospital in November 1946, with a mass in the breast of two and one-half years' duration. She had been followed by her L.M.D. who believed it to be a milk duct. She was three months pregnant with her third child. On examination a cord-like mass was palpable in the upper-inner quadrant. The clinical diagnosis was carcinoma of the breast. The patient had biopsy of the mass, with frozen section and a radical mastectomy. The final diagnosis was adenocarcinoma of the breast with axillary metastases. She continued with her pregnancy and delivered a normal child. One and one-half years later she was treated with testosterone. Three years later, after having developed metastases to the lung, she developed a Horner's syndrome. Four and one-half years after surgery she was admitted with metastases to the lumbar spine. She was given X-ray therapy and died in July 1952, six years after surgery.

3. L. P., 562740. This twenty-four-year-old female entered this hospital in August 1956, with a mass in the upper-inner quadrant, of three weeks' duration. She was six months pregnant with her fourth pregnancy. Examination revealed a small mass which was thought to be benign. At operation, a breast biopsy and frozen section were done and followed by radical mastectomy. Diagnosis: Ductile carcinoma with no axillary metastases. She is continuing her pregnancy.

4. L. B., 528034. This forty-year-old female entered this hospital in May 1953, with a mass in the breast of one year's duration. She had been delivered of her third child six weeks prior to admission, and was lactating. Examination revealed a mass occupying the upper half of the left breast, thought to be cystic mastitis. At operation, a biopsy with frozen section, followed by radical mastectomy was performed. The final diagnosis was adenocarcinoma of the breast with axillary metastases from a lactating breast. The patient died one year later with widespread metastases.

5. G. B., 422657. This forty-year-old female entered this hospital in July 1947, after noting a mass in the breast seven months prior to admission and then a second mass four months prior to admission. Her obstetrician had advised waiting until after delivery of this, her first, pregnancy. She entered the hospital two months after delivery. Examination revealed a mass under the nipple and another in the upper-outer quadrant, which were thought to be cystic mastitis. A breast biopsy and frozen section were done. One of the masses was reported to be cystic mastitis, but the other carcinoma of the breast and therefore a radical mastectomy was performed. The final pathologic diagnosis was adenocarcinoma of the breast with axillary metastases and chronic cystic mastitis. She received no other treatment and is alive and well nine years and four months following surgery.

6. L. P., 436914. This twenty-eight-year-old white female entered this hospital in January 1944 after noting drainage from the nipple of three-weeks' duration. Examination revealed a tangerine-sized mass under the right nipple. This was excised and found to contain pus. The pathologic diagnosis was breast abscess. She then became pregnant and was followed in the Tumor Clinic until December 1944 when, while eight months pregnant, she was readmitted with a clinical diagnosis of cancer of the breast. A simple mastectomy was performed. Pathologic diagnosis was Paget's disease of the breast. In April 1945, an oophorectomy was done. One year later an axillary dissection was performed. The pathologic diagnosis was adenocarcinoma, metastatic to lymph nodes. In July 1946 she was given X-ray therapy and testosterone. In May 1948 bony metastases were noted and the patient died in July 1948 of widespread disease. She died four and one-half years after initial treatment.

7. L. A., TC46-7580. This forty-year-old female entered this hospital in November 1946 with a mass in the breast of two years' duration. She was six months pregnant with her fourth child. Examination revealed a mass in the upper-outer quadrant which was thought to be a carcinoma. An excisional biopsy was performed. Pathologic diagnosis was adenocarcinoma of the breast. The patient was allowed to deliver normally. She was treated with X-ray therapy and testosterone. Six months later she was readmitted to the hospital for radical mastectomy. This was performed, and the final pathologic diagnosis was adenocarcinoma of the breast with axillary metastases and radiation reaction. She was last heard from in December 1950, four years after initial treatment, without evidence of metastases, and living in British Guiana.

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## MAJOR ISSUES IN PROPOSED SOCIAL SECURITY FOR PHYSICIANS

*concluded from page 159*

The Achilles heel in the body of voluntary health insurance may be in the limited extent to which the retired aged are protected. There seem to be growing demands that OASI be expanded to include medical-care benefits for old-age beneficiaries. Incidentally, this proposal is not new; you may recall that Oscar Ewing was urging the same general plan when he was Federal Security Administrator.

If the past is any guide, it seems likely that voluntary health insurance will solve the problem of providing more adequate protection for the retired aged. In particular, there are encouraging new developments in adding group health insurance protection for retired employees to employer and union welfare programs.

However, voluntary health insurance cannot do the entire job over night. The new policies mainly give protection in retirement to employees now active. For a temporary period, there will continue to be a partial vacancy—enticing to the proponents of compulsory health insurance. If their noses should enter the tent, a general socialized medicine program might follow.

### *Could Medicine Speak Best Inside or Outside of OASI?*

This foreboding possibility leads to a question I raised at the outset—would the medical profession be able to speak more effectively in Washington on social security matters, if inside or outside the OASI system? As I see it, there are three answers to this question, depending on the type of matter being considered.

If the issue is one affecting the practice of medicine—such as a proposal to add more disability benefits or some medical-care benefits to OASI—then doctors are qualified to testify as experts. On such an issue, I think it would make little if any difference whether the doctors were themselves covered by the system.

If the issue is a general social security one, not affecting the practice of medicine, then it seems to me, doctors would have little reason to testify, and little weight if they did, unless they were themselves covered by OASI. I can imagine a Congressman thinking: "What business is it of the doctors to concern themselves with a proposed increase in social security taxes and benefits, if they are themselves outside the system?"

The third kind of issue I have in mind is the sort posed by the so-called Jenkins-Keogh Bill. This proposal is one to give favorable income-tax treatment to sums set aside for their retirement by doctors and by other self-employed people. Here I can imagine a Congressman asking: "Why should we give doctors this special tax treatment, when they are unwilling to come under the general retirement system Congress has set up?"

### CONCLUSION

Well, I have finished outlining what seem to me to be the major issues raised by the proposed OASI coverage of physicians. And I have indicated my own thoughts about each.

In conclusion, I must confess it all adds up to nearly nothing—in other words, that the *cons* just about balance the *pros*. Perhaps, as I see it, there is a bit more to be said in favor of OASI coverage for doctors than against it. However, the difference is not great. And, depending on the relative importance one attaches to the various points, he could easily reach the opposite conclusion.

Gentlemen, it is your decision. It is your views which will decide the question, not mine. Thank you.

## RHEUMATIC CARDITIS IN LATE ADULT LIFE

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but may be aided by repeated O-antistreptolysin titres. The recent advances in prevention of the rheumatic state by the use of penicillin prophylaxis, and the ameliorating effect of the corticosteroids accentuate the need of developing more accurate diagnostic tests. A high index of correlative clinical suspicion, however, will continue to be of high value.

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*106 Francis Street, Providence, Rhode Island*




## TESTS OF ALCOHOLIC MOTORISTS

ONE DEFINITE STEP against the highway traffic toll will be taken with the enactment of the legislation proposed to the General Assembly for the chemical testing of motorists alleged to have driven vehicles while under the influence of alcohol. The proposed statute, introduced by the request of the Rhode Island Council on Highway Safety, has been subject to review by the Highway Safety Committee of our Society. The Committee has given full support to the program, and it has worked closely with the State Council to make the legislative act one that is workable and enforceable.

The act includes an "implied consent" provision under which all licensed drivers accused by police of driving while under the influence of intoxicating liquors will be required to submit to any of the tests, except blood testing. To avoid possible challenge that the reception of evidence of blood tests for intoxication would violate the state statute based on the privilege against self-incrimination, the act provides that "only a physician or medical technician acting with the express consent of the accused may withdraw any blood of any person submitting to a chemical test."

The state department of health will be the agency to approve satisfactory techniques or methods, and to ascertain the qualifications and competence of equipment and individuals to perform such tests, and to issue permits which shall be subject to termination or revocation at the discretion of the department.

We may expect that many objections, legal and otherwise, will be raised before the legislation is enacted by the General Assembly. However, we certainly hope that such differences will be speedily resolved, and the legislation placed on record. We are losing too many lives, and we are witnessing too many needless accidents with their devastating toll of injuries, to permit quibbling over minor technicalities of statute wording.

There are sufficient safeguards in the bill to protect the individual, and to any claim that the proposed legislation is an undue invasion of the right of privacy, in that it requires consent to a chemical test to determine the presence of alcohol in the blood system sufficient to make the accused a highway menace, should have little consideration. There is certainly no great personal indignity involved which would invalidate an otherwise valid utilization of the police power.

We would express a word of caution, however, to all police authorities that they may not look upon the chemical test as the main solution to the

highway accident problem. Certainly it is a means to assist in convictions for drunken driving, but the rights of the accused to have also an examination by his own physician must still prevail.

Therefore it is apparent that our respective cities and towns should give more serious consideration to the appointment, in each locality, of a physician on call by the police department, on a fee or salary basis, for the prompt examination of all persons alleged to have driven vehicles while under the influence of intoxicating liquors. When one considers the sizable income derived by the state from vehicle registrations and motorists' licenses, it is indeed strange that some of these funds are not available to assist the law enforcement authorities in keeping the highways clear of drivers who disregard the safety of their fellow citizens.

Prompt examination by an assigned doctor of medicine responsible to the police authorities, plus the chemical test, would go far toward solving this serious problem with which all of us have been grappling in recent years.

## SOCIAL SECURITY

The pros and cons of the major issues involved in the proposed coverage of physicians under the Compulsory Federal Social Security System were excellently set forth, at the Annual Meeting of the Providence Medical Association, by Mr. Kendrick, Research Associate of the Life Insurance Association of America, and an authority on the Old Age and Survivors Insurance program of the government. We are pleased to publish his address in this issue of the JOURNAL (see page 156).

Although Mr. Kendrick concludes that "the cons just about balance the pros," yet he feels that there is a bit more to be said in favor of OASI coverage for doctors than against it. He bases his premise, as we review his address, mainly on the economic factor—that OASI can be considered a "good buy," with the participants, on the whole, getting their money's worth.

On the question of principle and philosophy Mr. Kendrick is negative, preferring to view the entire question of Social Security from an economic standpoint. Therein, we feel, lies the major fault in his analysis—an analysis that is excellent from an economist's point of view, but not from a physician's.

The big question of principle and philosophy that still remains unanswered, and probably can only be answered by the individual physician is—

If the physician believes the federal government should compel him, and every other citizen, to pay into a tax fund to provide benefits for his old-age insurance and retirement, and protection for his survivors in the event of an early death, then does he not have to agree to the logical corollary that the government would be justified in taxing him and everyone else to provide medical care for all under a compulsory system. Before he consents to join any compulsory Social Security System, the question which he should thoughtfully consider is this—Am I willing to exchange my personal economic liberty for promises of material welfare? Should the medical profession decide to surrender one liberty, it will surely be invited or even compelled, later on, to surrender others. Certainly, we should look before we leap.

## BETTER CARE FOR LESS COST

A recent release from the Health Information Foundation, comes as a welcome change from the usual reports of increasing medical costs.

Having a baby is not only safer today than it was twenty-five years ago, but measured in equal dollars, it is also eighteen per cent less expensive. Total obstetrical care during the 1928-1931 period averaged $258 in terms of the present day dollar. In 1953, total obstetrical care averaged $213.

These figures are all the more significant considering the cost of all medical care, when one realizes that seventeen per cent of hospital admissions in 1953 were obstetrical admissions.

According to the Health Information Foundation, Americans have consistently spent approximately the same proportions of their expendable incomes—four to five per cent—for medical care each year for the past twenty-five years. Yet, a much broader range of diagnostic and treatment facilities are now available to more people than ever before, for the same relative cost.

## THE ANSWER IS "NO!"

In its report regarding physicians the Northeastern Regional Committee on Professional and Occupational Licensing advances a recommendation with which we cannot concur. In its study for the elimination of obstacles to the interchange of qualified license holders, the committee makes the following recommendation:

> "Qualifications for original licensure (of physicians) are similar in all states, and while there is general agreement on training standards, Rhode Island's requirement that physicians pass a separate examination in the basic sciences may pose a problem in licensing physicians from other states. The Committee recommends that Rhode Island accept the usual medical examination as given in other states, in lieu of a separate examination in the basic sciences."

This committee's conclusion is so general that it makes one wonder how much study went into the report. In the first place, the basic science examination is for all healers, not merely for doctors of

*concluded on next page*

medicine. In the postwar era we faced an influx of quasi-healers of such cults as naturopaths, drugless healers and the like. The chiropractors sought to secure by legislative rule what they could not attain by educational efforts. Out of this maelstrom emerged one of the finest basic science laws in the nation, which has effectively screened every would-be healer before he was permitted to take the next step forward to a professional examination.

The basic science law will keep out the uneducated whatever his schooling. It may be inconvenient for a physician to take the examination after he has been in practice elsewhere for several years, but we question that it causes him any hardship. And even if it does, our concern is not for the physician, but for the people of this state among whom he would work as a licensed healer of the sick.

The Northeastern Regional Study Committee overlooked the most important—and fundamental fact—the basic science law in Rhode Island was enacted to protect the public, not the physician.

## THE CORNER DRUGGIST

Through the years, we of the medical profession in this compact, friendly and highly organized state have always been conscious of the highly ethical standards of our pharmaceutical representatives, particularly the druggists in our various neighborhoods. We have indeed been fortunate that the close bond of understanding which has developed through the years has made our area unique in this great nation.

Not long ago we were privileged to read a letter, written by a Rhode Island resident to a large pharmaceutical company, that eulogizes our pharmacists in a most engaging manner. The correspondent wrote as follows:

> My pharmacist is the owner of a corner drugstore. If I haven't a car, "my druggist" delivers my orders (sometimes very small ones) cheerfully. Even more important, in a neighborhood such as ours, he will not give medical advice. Oh, he'll always help with a sunburn or a post-holiday bellyache—but he does no prescribing. His insistence on prescriptions is welcome in this time of rather shoddy ethics and the indiscriminate use of possibly dangerous drugs and antibiotics. The physicians like and trust him. . . .

Perhaps not all of the druggists are like the one who has been described above. We would like to think so—and will continue to think so until it is proved to us otherwise, for we too, are proud of the pharamacists in Rhode Island for their great contribution to the healing art.

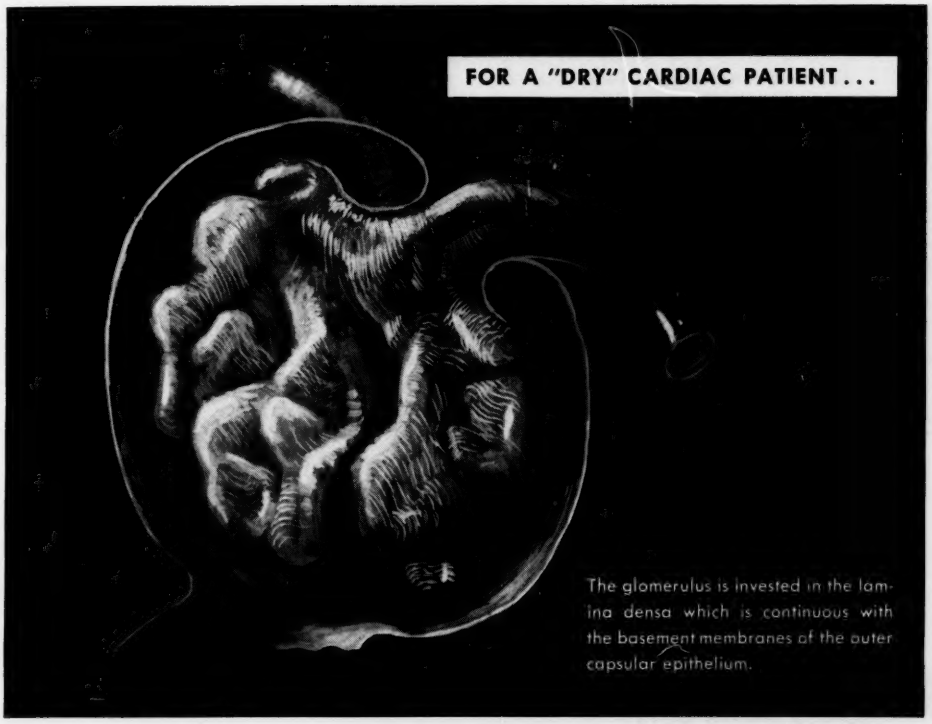



*Illustration by Hans Elias*

# *Rolicton® Diuresis Maintains Continuous Edema Control*

The efficacy of Rolicton (brand of amisometradine) in maintaining diuresis in the edematous patient has been established on an average dosage of one tablet b.i.d. Larger doses may be given as initial therapy and as maintenance therapy in edema difficult to control. Many patients will respond to one tablet daily.

"The margin of safety and the diuretic index is certainly an improvement over the use of oral mercurial diuretics."[1]

*Avoiding "Peaks and Valleys"*

A highly desirable effect, and one which has been made possible with Rolicton, is the maintenance of continuous diuretic effectiveness day after day over an extended period, to avoid the up-and-down weight pattern typical of other edema-control methods.

"There was an obvious stabilization of weight in practically all of the patients under observation, and previous wide fluctuations in poundage disappeared."[2]

*Mercury-Sparing*

Typical of the Rolicton diuresis pattern is the ability of the drug to reduce and, in a large percentage of patients, to eliminate the need for mercurials parenterally.

". . . the drug represents a most useful addition to our armamentarium in the treatment of edema, not only because it can be given orally . . . but more so because it permits [us] to replace or to spare the . . . mercurials."[3]

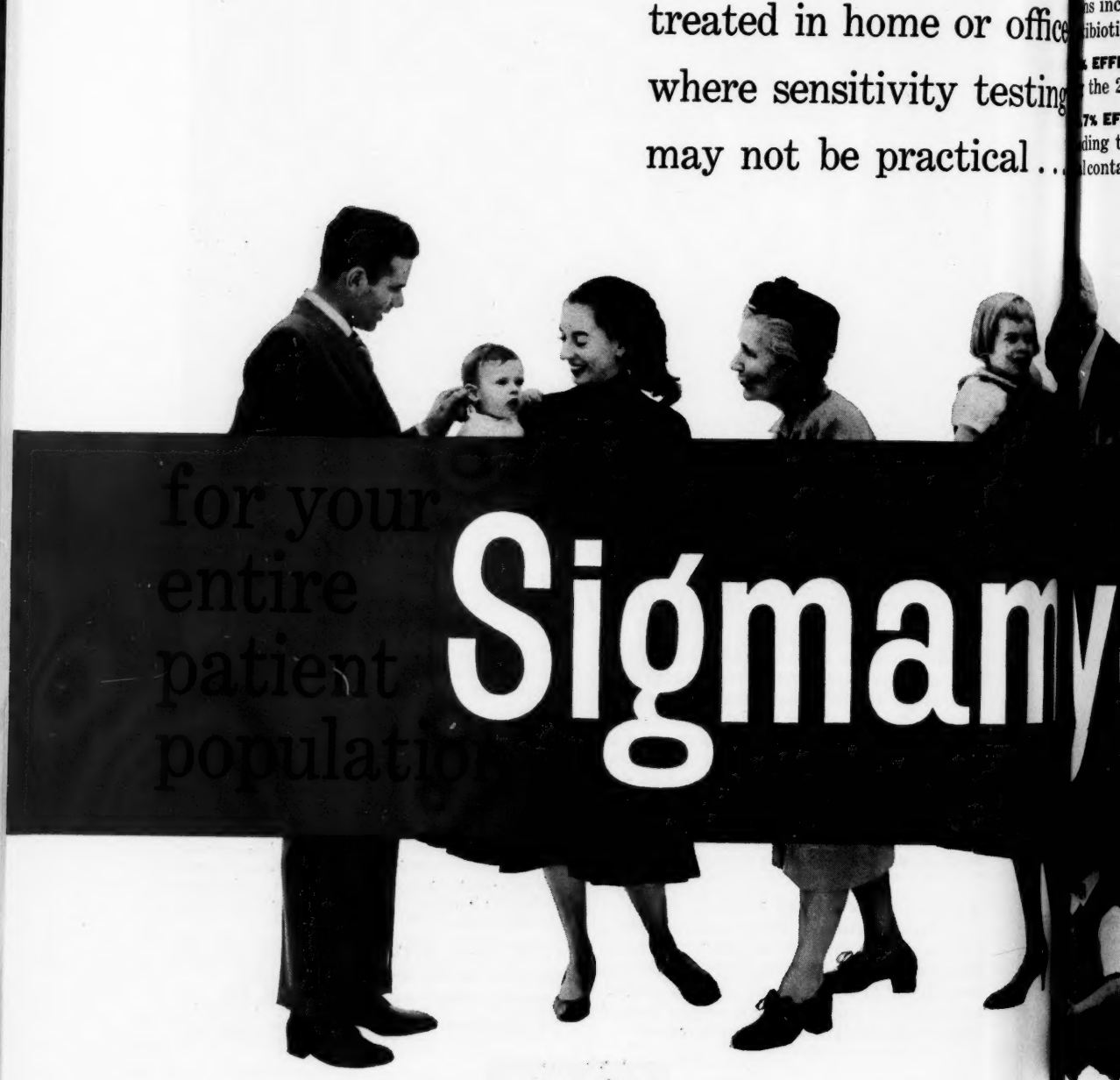
G. D. Searle & Co., Chicago 80, Illinois.
Research in the Service of Medicine.

1. Asher, G.: Personal communication, June 23, 1956.
2. Settel, E.: A Clinical Evaluation of a New Oral Diuretic, Rolicton, Postgrad. Med., Feb. 1957, in press.
3. Goldner, M. G.: Personal communication, June 29, 1956.

SEARLE

# added certainty in antibiotic therapy

—particularly for that 90%
of the patient population
treated in home or office
where sensitivity testing
may not be practical...



**% EFFECTIVE** in respiratory infections luding the 25% due to resistant phylococci.[1-3]

**EFFECTIVE** in dermatologic and mixed t tissue infections including the 22% istant to one or more antibiotics.[3-6]

**6% EFFECTIVE** in genitourinary infecns including the 61% resistant to other ibiotic therapy.[2,5]

**EFFECTIVE** in diverse infections includ- the 21% due to resistant pathogens.[1,5]

**7% EFFECTIVE** in tropical infections inding those complicated by heavy bacteI contamination or multiple parasitisms.[7]


1. Carter, C. H., and Maley, M. C.: Antibiotics Annual 1956-1957, New York, Medical Encyclopedia, Inc., 1957, p. 51. 2. Shalowitz, M., and Sarnoff, H. S.: Personal communication. 3. Shubin, M.: Personal communication. 4. La Caille, R. A., and Prigot, A.: Antibiotics Annual 1956-1957, New York, Medical Encyclopedia, Inc., 1957, p. 67. 5. Winton, S. S., and Cheserow, E.: Antibiotics Annual 1956-1957, New York, Medical Encyclopedia, Inc., 1957, p. 55. 6. Cornbleet, T.: Personal communication. 7. Loughlin, E. H.; Mullin, W. G.; Alcinder, L., and Joseph, A. A.: Antibiotics Annual 1956-1957, New York, Medical Encyclopedia, Inc., 1957, p. 63.


†the antimicrobial spectrum of tetracycline extended and potentiated with oleandomycin (Matromycin®) to combat resistant strains of pathogens—particularly resistant staphylococci —and to delay or prevent the emergence of new antibiotic-resistant strains.


**SUPPLY**
CAPSULES: 250 mg. (oleandomycin 83 mg., tetracycline 167 mg.). Bottles of 16 and 100.
*new mint-flavored* ORAL SUSPENSION: 1.5 Gm., 125 mg. per 5 cc. teaspoonful (oleandomycin 42 mg., tetracycline 83 mg.) 2 oz. bottle.

*TRADEMARK

Pfizer PFIZER LABORATORIES, *Division, Chas. Pfizer & Co., Inc.*, Brooklyn 6, N. Y.
*World leader in antibiotic development and production*

# CONTINUED PROGRESS FOR PHYSICIANS SERVICE

## Address of the *President,* CHARLES J. ASHWORTH, M.D., to the Corporation of Rhode Island Medical Society Physicians Service at its Eighth Annual Meeting, January 30, 1957

ONE OF THE intriguing questions that occurred to me when I set about to prepare this report as your president, was: What would one say if a year of progress had not been recorded? It has very somber if not terrifying implications, and while each of you and every member of our Society will, on this occasion, be spared that unpleasant contemplation, I trust that its mention will emphasize for you as it has for me, the impact and importance that Physicians Service has upon our professional lives.

Now entering upon its eighth year, Physicians Service finds itself healthy for the present and hopeful for the future. It might seem paradoxical to characterize the plan as contained, but expansile, and yet this is precisely the case. Some of the printed data about our experience in 1956 is convincing.

Outstanding in the year's achievements was the enrollment of the 500,000th subscriber, something that was not viewed with unrestrained enthusiasm in the early days and raises to 61.76 the percentage of state population now enrolled. In the entire country, this is second only to Delaware and the margin of difference is only 0.8%.

It is significant to point out that during the year the program paid out in benefits to subscribers over five and one-half million dollars, and at the same time the plan was administered with the lowest operating expense ratio in the entire country.

I am sure that no one will disagree that your plan, Rhode Island Medical Society's Physicians Service, is something in which one can take some justifiable pride. Your Corporation is most fortunate in having an executive director, and an associate director, whose experience and knowledge has been mainly responsible for the success we now enjoy. I cannot emphasize for you the plain thanks we owe to these men in our employ, for an outstanding job they have done for us as reflected in the figures you have at hand. Stanley H. Saunders, our executive director, a sectional representative for the National Blue Shield Plans, and his associate, Edgar H. Clapp, together with all the members of their administrative group, deserve our commendation. My personal thanks goes to them and I am sure in that expression of appreciation I voice the sentiment of this entire Corporation.

No report would be complete without a word of gratitude and deep appreciation to the lay members of your Board of Directors for the time, effort and unstinting sacrifice they have given in this year just ended, securing for you and the public we serve, the place of Rhode Island Medical Society's Physicians Service as one of the outstanding plans of its kind in this whole country.

So much for the past. What do we look to in the proximate future? The various committees of your Board, mindful of our obligation to provide the people of this community with the best and the most in medical service that our financial structure will permit, are hard at work. Over one year ago, we offered an X-Ray benefit, unequaled by any other plan, and I am happy to report that our experience in this field has been highly satisfactory, thanks to our doctors who by splendid cooperation have made this new benefit an asset and not a liability. We look forward in this present year to further extension of benefits to our subscribers, perhaps in the field of radiation, or more important in extended coverage or major medical insurance.

Throughout this past year, a committee has been looking into various aspects of major medical insurance or as some choose to call it, catastrophic coverage, and in the very near future we will have the benefit of that committee's study, perhaps enabling us to offer the people of Rhode Island a sound, comprehensive and economical contract that will implement the coverage we now offer. I cannot at this time make it clear how extremely difficult a project of this magnitude is. All I can say is that we are most grateful to those members of the Board who are struggling with the many aspects of such a problem, in order to make it practicable and realistic for both doctors and subscribers.

Dwight H. Murray, president of the American Medical Association, so well said on the occasion of his address to the House of Delegates of the American Medical Association at Seattle just a

*concluded on page* 176

# *New*—A Faster-Acting More Effective Spasmolytic

*In a series of 120 patients with diverse complaints such as gas, bloating, nausea, cramps, etc. referable to the g.i. tract, Olson[1] obtained "rapid symptomatic relief" in 92 cases with* COACTYN, *a new pH-adjusted phosphorated carbohydrate solution containing homatropine methylbromide and phenobarbital.*

Significantly, in those cases which were *functional* in nature, the relief obtained was "more satisfactory than with usual antispasmodic or anticholinergic medications."

AND

"When Coactyn did not afford relief from symptoms, further diagnostic procedures in most instances revealed organic lesions of the g.i. tract."

ABSTRACT OF CASE REPORT

A 42-year-old white female complained of severe gas and bloating after eating "almost anything." She had had a cholecystectomy. Abdominal distention was so marked as to raise the question of pregnancy. Cramping became so severe that parenteral anticholinergics were sometimes required, with but partial relief. A g.i. series revealed only hypermotility and spasticity of the entire g.i. tract. Among the drugs which had been tried were estrogens, sedatives, almost all of the available antispasmodics, and numerous alkaline buffering agents. None gave satisfactory relief. Administration of COACTYN resulted in "almost complete alleviation of symptoms." The patient was able to tolerate a better balanced diet. The author calls attention to the "topical" antispasmodic effect of the pH-adjusted phosphorated carbohydrate solution.

FORMULA:
Each teaspoonful contains 0.5 mg. homatropine methylbromide and 8 mg. phenobarbital in a phosphorated carbohydrate solution with the pH of the entire preparation adjusted at an optimally effective level. Alcohol 9.5%. Pleasantly apricot-flavored.

DOSAGE:
1 or 2 teaspoonfuls, *undiluted,* 15 minutes before meals; additional doses if necessary.

SUPPLIED:
Bottles of 3 fl.oz. and 16 fl.oz.

1. Olson, J. A.: Am. J. Digest. Dis., Nov., 1955.

# Coactyn
TRADEMARK

Kinney **KINNEY & COMPANY, INC., Columbus, Indiana**

# RHODE ISLAND MEDICAL SOCIETY PHYSICIANS SERVICE

## *Report of the Eighth Annual Meeting of the Corporation, January 30, 1957*

THE EIGHTH Annual Meeting of the Corporation of the Rhode Island Medical Society Physicians Service was held at the Rhode Island Medical Society Library, Providence, on Wednesday, January 30, 1957. The meeting was called to order by the President, Doctor Charles J. Ashworth, at 8:35 p.m.

The following members of the Corporation were in attendance:

Charles J. Ashworth, M.D.
Robert R. Baldridge, M.D.
Irving A. Beck, M.D.
Alex M. Burgess, Jr., M.D.
Bertram H. Buxton, Jr., M.D.
Wilfred I. Carney, M.D.
William B. Cohen, M.D.
Frank B. Cutts, M.D.
John A. Dillon, M.D.
Michael DiMaio, M.D.
Peter C. Erinakes, M.D.
Charles L. Farrell, M.D.
Wm. J. H. Fischer, Jr., M.D.
Henri E. Gauthier, M.D.
J. Merrill Gibson, M.D.
Seebert J. Goldowsky, M.D.
Stanley Grzebien, M.D.
Edmund T. Hackman, M.D.
Russell P. Hager, M.D.
John C. Ham, M.D.
Robert C. Hayes, M.D.
Joseph Hindle, M.D.
Walter S. Jones, M.D.
Ernest K. Landsteiner, M.D.
Thomas J. Lalor, M.D.
Joseph G. McWilliams, M.D.
William S. Nerone, M.D.
Thomas A. Nestor, M.D.
Thomas Perry, Jr., M.D.
Arnold Porter, M.D.
William A. Reid, M.D.
Louis A. Sage, M.D.
Orland F. Smith, M.D.
William J. Schwab, M.D.
James J. Sheridan, M.D.
George W. Waterman, M.D.
Hrad A. Zolmian, M.D.

Also present were Mr. Edgar J. Clapp, associate director of the Hospital Service Corporation of Rhode Island, Mr. J. Lewis Eddy and Mr. George Peterson of the administrative staff, and John E. Farrell, executive secretary.

### *Address of the President*

Doctor Charles J. Ashworth gave his presidential address in which he highlighted the work of the organization during 1956. His address is made part of the official records of the meeting.

### *Annual Report of the Secretary*

Doctor Ernest K. Landsteiner, secretary, read his annual report, copy of which is made part of the official records of the meeting.

*Action:* It was moved that the annual report of the secretary be received and placed on file. The motion was seconded and adopted.

### *Annual Report of the Treasurer*

Doctor Orland F. Smith, treasurer of the Corporation, read his annual report for the year 1956, copy of which is made part of the official records of the meeting.

*Action:* It was moved that the annual report be received and placed on file. The motion was seconded and adopted.

### *Election of Members to Board of Directors*

The secretary reported that the House of Delegates of the Rhode Island Medical Society had nominated for three-year terms to serve on the Board of Directors of the Rhode Island Medical Society Physicians Service until the Annual Meeting in 1960 the following:

William J. H. Fischer, Jr., M.D. (Providence)
Edmund T. Hackman, M.D. (Kent)
Earl J. Mara, M.D. (Pawtucket)
Orland F. Smith, M.D. (Providence)

*Action:* It was moved that these nominees be elected as members of the Board of Directors. The motion was seconded and adopted.

### *Tribute to Retiring Members*

Doctor Charles L. Farrell moved that the Corporation instruct its secretary to extend the appreciation of the organization to Mr. Emil Fachon, Doctor Frank B. Cutts, and Doctor Rocco Abbate for their long and valued service upon their retirement as members of the Board of Directors after serving for six years. The motion was seconded and unanimously adopted.

The meeting adjourned at 9 P.M.

Respectfully submitted,

ERNEST K. LANDSTEINER, M.D., *Secretary*

### *Annual Report of the Secretary*

During 1956 the Board of Directors of Physicians Service held five meetings and the Executive Committee held a similar number of meetings.

At the Annual Meeting of the Board the following officers were elected:

Charles J. Ashworth, M.D. ..... *President*
Rocco Abbate, M.D. ..... *Vice-President*
Ernest K. Landsteiner, M.D. ..... *Secretary*
Orland F. Smith, M.D. ..... *Treasurer*

Re-elected as the non-medical members of the

Board as representatives of the public, were: Messrs. James R. Donnelly, Emil E. Fachon, Walter F. Farrell, John J. Halloran, Felix A. Mirando, and George R. Ramsbottom.

The steady development of Physicians Service has entailed additional work for the Claims Committee which was increased during the year to ten members, with additional consultants from certain specialty fields also included. The district society liaison committees were formed and to the best knowledge of the Board have served as an aid in the interpretation of problems of the Service to members of the medical profession in the various communities of the state.

The first complete year of X-ray coverage indicated that this additional benefit had been provided within the actuarial range predicted in advance of the establishment of the coverage.

A preliminary study was initiated on flexible or optional group benefits during the year to provide special coverage that might be sought under wage contracts.

Appended to this report is a summary comparison of statistics regarding the operation of Physicians Service in the years 1955 and 1956.

Respectfully submitted,

ERNEST K. LANDSTEINER, M.D., *Secretary*

### *Annual Report of the Treasurer*

The year 1956 completed the seventh full year since the beginning of the Medical Society's Voluntary Prepayment Medical Care Plan, and was no exception to our experience in the previous six years. Our total number of subscribers passed the half million mark with a grand total of 502,747 people of Rhode Island insured, who paid a total of $6,272,472.29 in subscription costs. With a small percentage of income from invested funds our total net income amounted to $6,341,009.49.

Of this amount, a total of $5,587,950.21 or 88.2% was expended in the payment of surgical-medical claims for professional service rendered to our subscribers.

Of the remaining 11.8% a total of $325,450.28 or 5.1% was needed for operating expenses, representing a drop of nearly one per cent over the previous year for a new low in cost of operation which paces all such similar plans in the nation.

Total reserves passed the one million dollar mark during 1956 for a total of $1,115,748.77. The statutory reserve nearly doubled during the year for a new total of $690,698.92 and the surgical-medical reserve increased by $100,602.68 for a new high of $425,049.85.

Investments increased from $1,297,793.97 to $2,032,012.72 or an increase of over $834,000.00. Accrual accounts for unpaid surgical, medical and

*concluded on next page*

maternity increased over one hundred thousand dollars to a new high of $945,454.00.

In conclusion, I am pleased to report that the stability of your corporation remains on a solid foundation, and the members of the Rhode Island Medical Society are to be congratulated for their individual and collective contribution to a plan that gives so much for so little.

Respectfully submitted,

ORLAND F. SMITH, M.D., *Treasurer*

## CONTINUED PROGRESS FOR PHYSICIANS SERVICE

*concluded from page* 172

few weeks ago: "Today there is greater need for a united, forceful and informed profession than ever before. We have been caught in the throes of a social revolution which demands something for nothing. Changes have been taking place all around us and medicine has not escaped unscathed."

Two of these changes are (1) Medicare and (2) self-financed plans for both basic coverage and extended coverage by labor groups and unions.

It is quite obvious that we are bound to lose to Medicare since individuals such as an employed spouse of an enlisted man might have Physicians Service with Blue Cross furnished by the employer, and if paid for in full, might keep it to offset the deductible feature written into Public Law 569. But, if the cost is going to be shared even in part by the subscriber, the chances of cancellation are great. Some study by our legal and administrative departments is already under way, because if the present Congress should amend the law to include greater numbers, our present security with a half million members becomes very vulnerable.

As to the union labor situation, it is still in the planning stage, but we are informed that it appears inevitable and may make devastating inroads upon Blue Shield, Blue Cross and all similar plans.

Some caution must be taken, but until the many points in dispute are settled in both government and labor, nothing in definite contract form can be expected to emerge.

The administration has proposed major medical expense insurance as a rider to its group life program for federal civilian employees, but a segment of the employees would prefer this added to a basic coverage contract rather than to a life program.

It is apparent that similar problems will have to be resolved by labor, but if and when they are, a plan like Physicians Service or Blue Cross will be subjected to some modification, the extent of which is not now measurable.

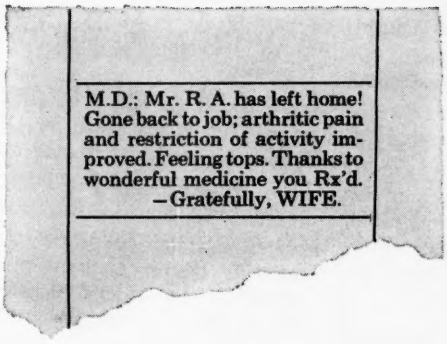
However, we can with confidence, continue our efforts toward procuring better health for more people, an objective worthy of a profession dedicated as it is, to that unrelenting service to humanity, *the care of the sick.*

***Rhode Island Medical Society Physicians Service***
***Comparison of Statistics—Years 1955 & 1956***

| | *1955* | *1956* | *Increase or (Decrease)* |
|---|---|---|---|
| Subscribers | 469,147 | 502,747 | 33,600 |
| Number of Firms Buying Physicians Service | 776 | 803 | 27 |
| Number of Participating Physicians | 835 | 883 | 48 |
| Claims Paid to Physicians | $4,378,012 | $5,587,950 | $1,209,938 |
| Total Payments to Physicians Since Start of Plan | $15,162,573 | $20,750,523 | $5,587,950 |
| Total Assets | $2,171,600 | $2,742,285 | $570,685 |
| Total Income | $4,890,222 | $6,341,009 | $1,450,787 |
| Total Reserves | $699,754 | $1,115,749 | $415,995 |
| Operating Expenses | $289,417 | $325,450 | $36,033 |
| Operating Expense — % | 5.9% | 5.1% | (0.8%) |
| Claims — % | 89.5% | 88.2% | (1.3%) |
| *Number of Cases:* | | | |
| Surgical* | 64,800 | 73,185 | 8,385 |
| Assistants* | 11,586 | 12,659 | 1,073 |
| Anesthetists* | 23,811 | 26,978 | 3,167 |
| Medical | 10,300 | 12,033 | 1,733 |
| X-Ray & EKG | 13,468 | 75,112 | 61,644 |
| TOTAL | 123,965 | 199,967 | 76,002 |
| *Maternity Cases (included in above) | 10,131 | 10,633 | 502 |

Percentage of State population enrolled — 61.76%. This ranks second in the nation, Delaware being 62.56%; Washington, D. C., 53.9%; Michigan, 47.32%; and Connecticut 43.95%.

Rhode Island's operating expense ratio of 5.1% is the lowest among Blue Shield Plans. For 9 months of 1956, Wilmington's ratio was 7.17%; Massachusetts — 7.34%; New Hampshire — 7.58%; Michigan — 7.71%; Washington, D. C. — 9.28%; and Connecticut 10.94%.



# DISTRICT MEDICAL SOCIETY MEETINGS

## WASHINGTON COUNTY SOCIETY

The annual meeting of the Washington County Medical Society was held at the Westerly Nurses' Home, Westerly, Rhode Island, January 9, 1957. The meeting was called to order at 11:40 A.M. by the president, Doctor Martin O'Brien.

The minutes of the previous meeting were read and approved.

*UNFINISHED BUSINESS:* Dr. Nathans made a motion that the Washington County Medical Society do not take a definite stand in the setting of physicians' fees in this area, rather that this be taken care of by the physicians in the individual areas in the county. The motion was seconded by Doctor Ruisi and passed.

*COMMUNICATIONS:* Various portions of the weekly *Secretary's Letters* were read.

Letters from Jacob Warren and Norman Garrison, M.D. announcing their resignation from the Washington County Medical Society. Each has moved from Washington County.

MILDRED I. ROBINSON, M.D.
*President, 1957*
*Washington County Medical Society*

*MEMBERS PRESENT:* Doctors Agnelli, Capalbo, Celestino, Cerrito, Chimento, Eckel, Farago, Gale, Gongaware, Grainger, Jones, Manganaro, McGrath, Morone, Nathans, O'Brien, Robinson, Ruisi, Spicer, Tatum, Walsh, DeWees, Tang, Johnson. Excused: Doctors Potter and Hathaway.

*TREASURER'S REPORT:* The treasurer's annual report was read by Doctor Gale. Doctor Nathans moved and Doctor Manganaro seconded that the report be accepted. The motion was passed.

*DEPENDENTS MEDICAL CARE PROGRAM:* Doctor Nathans reviewed the situation regarding the federal dependents medical care plan in Rhode Island. There was general discussion of the program.

*NEW BUSINESS:* Doctor Jones made a motion that a special joint meeting be held in March at which the film on *The Medical Witness* could be shown to members of the Washington County Medical Society, the Washington Bar Association and the Washington Dental Society.

Doctor Spicer presented a booklet called *Diet or Die* which is for sale to the public and which claims cancer can be cured by diet alone.

Doctor Agnelli moved that this booklet be referred by Doctor Gongaware to the Rhode Island Cancer Society for appropriate action.

*ELECTION OF OFFICERS:* Doctor Nathans moved that Doctor Tatum be elected treasurer and financial advisor for the Society. Seconded by Doctor Jones and passed.

The officers for the ensuing year, nominated and elected by a unanimous vote, were as follows:

| | |
|---|---|
| President | Mildred Robinson, M.D. |
| First Vice-president | Fred Eckels, M.D. |
| Second Vice-president | James McGrath, M.D. |
| Secretary | E. T. Gale, M.D. |
| Treasurer | Julianna R. Tatum, M.D. |
| Councillor ('56 & '57) | Samuel Nathans, M.D. |
| Alternate ('56 & '57) | Joseph Ruisi, M.D. |
| Delegates (to 1958) | Thomas Nestor, M.D. |
| (to 1959) | Hartford Gongaware, M.D. |
| (to 1960) | James McGrath, M.D. |
| Censors | A. L. Manganaro, M.D. |

Bruno Agnelli, M.D.
William Tully, M.D.
Auditor ..... Henry Potter, M.D.

Upon motion of Dr. Agnelli, Dr. O'Brien was given a unanimous vote of appreciation for his term of presidential guidance.

The meeting was adjourned at 1:30 P.M., after which a luncheon was held in the hospital dining room.

Respectfully submitted,
E. T. GALE, M.D.

## NEWPORT COUNTY SOCIETY

A meeting of the Newport County Medical Society was held at the Hotel Viking on January 30, 1957. The meeting was called to order at 8:15 P.M. Dr. John Malone, president, presiding. The reading of the minutes of the previous meeting was dispensed with. Dr. Adelson reported for the Council and discussed the Council's attitude on Medicare and the associated fee schedule. He also asked for volunteers to serve on specific committees of the state society. Dr. Brownell reported that there had been no meeting of the Delegates since September 1956.

Under new business the annual election of officers was held. All of the previous officers were returned to office for a second year as follows:

President ..... John M. Malone, M.D.
First Vice President ..... C. Barrus Ceppi, M.D.
Second Vice President ..... Jose Ramous, M.D.
Secretary ..... Donald B. Fletcher, M.D.
Treasurer ..... Edward Zamil, M.D.
Councillor ..... Samuel Adelson, M.D.
Delegates ..... Henry W. Brownell, M.D.; Charles Serbst, M.D.
Censors ..... Norman MacLeod, M.D.; Daniel Smith, M.D.

The question of fee schedule was raised and it was pointed out that nothing had been heard from the State Committee to make recommendations regarding fees. A motion made by Dr. Bestoso and seconded by Dr. McAllister to raise office fees to a minimum of $4.00 and house calls to a minimum of $6.00 was tabled by vote. A motion made by Dr. Dotterer and seconded by Dr. Ciarla to appoint a committee to investigate fees throughout the state and bring back recommendations to the next meeting was also tabled by vote.

The speaker of the evening was Captain Milton Worthlin, Commanding Officer of the Newport Naval Hospital. He was introduced by Dr. John Carey. The speaker discussed various aspects of Medicare. Among other things he pointed out that all service dependents should receive the care that a few had been getting. He discussed the history of dependent care by the services and the importance of keeping trained personnel in the services by this fringe benefit. He reviewed the history of the writing and passage of the bill. He said that the service was attempting to get the same benefits for its personnel that industry has. He discussed the nature of the act and its administration. There was a considerable question and answer period.

Meeting adjourned at 9:30 P.M.

Respectfully submitted,
DONALD B. FLETCHER, M.D., *Secretary*

## PAWTUCKET MEDICAL ASSOCIATION

A dinner meeting of the Pawtucket Medical Society was held at the Lindsey Tavern at 6:30 P.M. on Thursday, January 17, 1957. Dr. Raymond T. Stevens presided.

The following members were present: Drs. Gordon, Forgiel, Jeremiah, F. Hanley, Czekanski, Mara, Morris, Senseman, R. T. Stevens, Lappin, Kelley, Bleyer, Farrell, Sonkin, Zolmian, Lussier, Fortin, Lovering, E. Gaudet, Billings, Hennessey, H. Turner, Webster, Metcalf, Paull, Gorfine, Hecker, R. Jaworski, Damargian, Sprague, H. Hanley, Ruggles, Cunningham, Pinault, Chapman, Stapans, and Mathewson.

The minutes for the previous meeting were read and approved.

Dr. Stevens made several suggestions for safeguarding Doctors' bags in view of the recent theft of bags.

He also named the nominating committee which included Dr. Kelley as chairman and Drs. F. Hanley, Zolmian, Woodcome and Sonkin.

Communications were read and included the following:

1.) Application for admission to the society by Dr. John Mulvaney.

2.) Application for associate membership by Dr. Stanley Simon.

*concluded on next page*

3.) Letter from Dr. Forgiel in which he requested that he be transferred from associate membership to active membership.

4.) Letter from the Grievance Committee of the Spatula Club.

Following dinner, Dr. Senseman spoke on his recent trip to the Near East and Europe. His talk was illustrated with beautiful colored slides. It was received with general applause.

The business aspect of the meeting continued. Dr. F. Hanley reported that the committee had completed its revision of the by-laws and that the revision was ready for the press.

Dr. Olga Koropey's application for admission to the society was voted upon and passed on written ballot. Dr. Peter Chudolij's application for admission to the society was voted upon and passed on written ballot.

Dr. Hennessey next discussed the function of the standing committee in regard to new members' applications.

Dr. Kelley made a motion that the letter from the Grievance Committee of the Spatula Club be acknowledged and that this letter state that the application of one of the doctors mentioned is now pending before the society and that the society would like to have specific instances of proof of the allegations and that this proof be turned over to the standing committee. Dr. Farrell seconded the motion and it was carried.

The meeting adjourned at 10:15 P.M.

Respectfully submitted,

NATHAN SONKIN, M.D., *Secretary*

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***Wednesday — June 12***

**Annual Golf Tournament and Dinner**

**of the**

**Providence Medical Association**

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## MILK COMMISSION REPORT — PROVIDENCE MEDICAL ASSOCIATION, 1956

CERTIFIED MILK in Providence during 1956 was obtained from the following farms: Cherry Hill Farm, North Beverly, Mass.; Hampshire Hills Farm, Wilton, N. H.; Hillside Farm, Cranston, R. I.

Through the courtesy and cooperation of the Boston Commission we have accepted their certification of one farm from Massachusetts and one from New Hampshire.

Bacteriological and chemical examinations of certified milk are made in the laboratories of Brown University under the supervision of Professor Charles Stuart. During the past year approximately 315 samples have been tested and we have found three bacteria counts above the legal standard among this group.

All of the herds are under State and Federal supervision and are free from Tuberculosis and Brucella abortus infections.

The Commission, four years ago, discontinued the sale of Raw Certified Milk in the Providence market to conform with the standards in most of the larger cities. The legal standard for Pasteurized Certified milk is still 500 colonies per ml. and the actual count on all samples examined by this Commission the past year was 34 colonies per ml. The prepasteurized count on this milk must be under 10,000 and actual count was 880 colonies per ml.

Vitamin D Certified Milk is defined as whole Certified Milk rendered antirachitic by irradiation or by the addition of a concentrate and shall be of sufficient vitamin potency to show, by biological assay, a content of at least 400 U.S.P. units per quart.

The Wisconsin Alumni Research Foundation of Madison, Wisconsin, is doing the assaying of Vitamin D from Hillside Farm and the results have been entirely satisfactory. Two tests per year are required by this Commission.

Certified Fat-free (Skim) Milk, containing not more than 0.05 per cent butter fat, and with Vitamin A added has conformed to the standards set by the American Association of Medical Milk Commissions.

One of the farms had some difficulty with spores which were present in small numbers and these were non-pathogenic. It was found that the most probable cause was dust from dry ensilage.

During the coming year we hope to see installed at one farm an apparatus which coats the outside of the bottles with Silicone spray. This improves the appearance of the glass and makes a better looking package. This spray is applied to the outside of the bottle only and since the material is inert the health hazard is practically nil.

The American Association of Medical Milk Commission in their Methods and Standards for the Production of Certified Milk, require that each producer shall make or have made, once per month, a titration of Brucella agglutinins in the whey of the milk, whether the milk is raw or pasteurized. All titrations on the whey of the milk obtained from raw milk from Hillside Farm during the past year have been negative.

The Commission is indebted to Professor Stuart of Brown University for his continued cooperation in supervising our laboratory work at Brown University.

FRANK I. MATTEO, M.D., *Chairman*
JOHN T. BARRETT, M.D.
D. WILLIAM BELL, M.D.
GEORGE E. BOWLES, M.D.
BERTRAM H. BUXTON, JR., M.D.
HAROLD G. CALDER, M.D.
JOHN E. FARLEY, JR., M.D.
JOHN P. GRADY, M.D.
HENRY E. UTTER, M.D.
REUBEN C. BATES, M.D., *Secretary*

### MONTHLY AVERAGES OF CERTIFIED MILK FOR 1956

| | CHERRY HILL H. P. HOOD | | | HAMPSHIRE HILLS | | | HILLSIDE FARM | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Pasteurized | | | Pasteurized | | | Pasteurized | | | Skimmed with Vit. A & D | | | Raw | | |
| | B.F. | T.S. | Bacteria per C.C. | B.F. | T.S. | Bacteria per C.C. | B.F. | T.S. | Bacteria per C.C. | B.F. | T.S. | Bacteria per C.C. | B.F. | T.S. | Bacteria per C.C. |
| January | 4.1 | 12.56 | 3 | 4.1 | 12.75 | 14 | 4.1 | 12.97 | 9 | 0.1 | 8.10 | 6 | 3.5 | 11.55 | 700 |
| February | 4.0 | 12.57 | 6 | 4.3 | 13.21 | 7 | 4.0 | 12.53 | 5 | 0.1 | 8.13 | 5 | | | |
| March | 3.9 | 12.33 | 7 | 4.2 | 12.97 | 14 | 4.2 | 12.80 | 4 | 0.1 | 8.39 | 5 | | | |
| April | 4.0 | 12.42 | 7 | 4.1 | 12.88 | 8 | 4.2 | 12.74 | 3 | 0.1 | 8.16 | 3 | | | |
| May | 3.9 | 12.29 | 9 | 4.2 | 12.69 | 17 | 4.2 | 12.75 | 5 | 0.1 | 8.24 | 3 | 3.5 | 11.65 | 420 |
| June | 3.9 | 12.28 | 4 | 3.9 | 12.45 | 22 | 4.2 | 12.80 | 8 | 0.1 | 8.38 | 4 | 4.7 | 14.49 | |
| July | 3.9 | 12.15 | 6 | 4.0 | 12.26 | 90 | 4.2 | 12.83 | 10 | 0.1 | 8.34 | 7 | 3.8 | 12.04 | 1550 |
| August | 4.0 | 12.24 | 8 | 3.9 | 12.35 | 67 | 4.4 | 12.89 | 10 | 0.1 | 8.14 | 9 | 3.5 | 12.15 | 850 |
| September | 3.9 | 12.30 | 23 | 4.0 | 12.51 | 29 | 4.2 | 12.64 | 9 | 0.1 | 8.06 | 12 | | | |
| October | 3.9 | 12.27 | 2 | 4.1 | 12.60 | 243 | 4.1 | 12.37 | 71 | 0.1 | 8.00 | 41 | | | |
| November | 4.0 | 12.46 | 9 | 4.0 | 12.49 | 198 | 4.0 | 12.30 | 25 | 0.1 | 8.16 | 38 | | | |
| December | 4.0 | 12.23 | 3 | 4.0 | 12.60 | 500 | 4.0 | 12.24 | 7 | 0.1 | 8.0 | 7 | | | |
| Yearly Average | 4.0 | 12.34 | 7 | 4.1 | 12.64 | 101 | 4.1 | 12.65 | 14 | 0.1 | 8.20 | 12 | 3.8 | 12.37 | 880 |

# HOUSE OF DELEGATES
## *of the*
# RHODE ISLAND MEDICAL SOCIETY
## *Report of Meeting held on January 30, 1957*

A MEETING of the House of Delegates of the Rhode Island Medical Society was held at the Medical Library on Wednesday, January 30, 1957. The meeting was called to order by the President, Doctor Charles L. Farrell, at 8 p.m. The following delegates were in attendance:

*Kent County:* Russell P. Hager, M.D.; Peter C. Erinakes, M.D.; Edmund Hackman, M.D. *Pawtucket District:* Robert C. Hayes, M.D.; Hrad A. Zolmian, M.D. *Washington County:* Thomas A. Nestor, M.D. *Woonsocket District:* Henri E. Gauthier, M.D.; Thomas J. Lalor, M.D. *Officers of the RIMS:* Charles L. Farrell, M.D.; John A. Dillon, M.D.; George W. Waterman, M.D.; Thomas Perry, Jr., M.D. *Immediate Past President of RIMS:* Frank B. Cutts, M.D. *Providence Medical Association:* Charles J. Ashworth, M.D.; Robert R. Baldridge, M.D.; Irving A. Beck, M.D.; Alex M. Burgess, Jr., M.D.; Bertram H. Buxton, Jr., M.D.; Wilfred I. Carney, M.D.; William B. Cohen, M.D.; Michael DiMaio, M.D.; William J. H. Fischer, Jr., M.D.; J. Merrill Gibson, M.D.; Seebert J. Goldowsky, M.D.; Stanley Grzebien, M.D.; John C. Ham, M.D.; Joseph Hindle, M.D.; Walter S. Jones, M.D.; Ernest K. Landsteiner, M.D.; Joseph G. McWilliams, M.D.; William S. Nerone, M.D.; Arnold Porter, M.D.; William A. Reid, M.D.; Louis A. Sage, M.D.; William J. Schwab, M.D.; James J. Sheridan, M.D.

Also in attendance were: Arthur E. O'Dea, M.D., chairman of the Highway Safety Committee; Francis B. Sargent, M.D., chairman of the Medical Defense and Grievance Committee; Richard P. Sexton, M.D., chairman of the Veterans Affairs Committee; Orland F. Smith, M.D., treasurer of the Rhode Island Medical Society Physicians Service; and John E. Farrell, Sc.D., executive secretary.

### REPORT OF THE SECRETARY

The Council has held two meetings since the last session of the House of Delegates. Among the actions taken were the following:

1. It approved the formation of a Medical Advisory Committee of the Registrar of Motor Vehicles of Rhode Island, and it authorized Doctor Arthur E. O'Dea, chairman of the Society's Highway Safety Committee, to submit names of members of the Society to serve on such a committee for one year terms.

2. It approved of the suggestion of the chairman of the Highway Safety Committee that a conference with police officials of the state be held by his committee.

3. It reviewed a report from the Committee on Mental Health on important phases of the study report compiled by the American Psychiatric Association acting as consultant to the Butler Hospital Board of Trustees.

4. It authorized the president of the Society to act for the Society to negotiate, execute and deliver for it such contracts or other agreements as might be necessary or proper in his opinion to aid in the fulfillment of the Dependents Medical Care Act for Rhode Island, and it expressed the opinion that no general revision of the proposed fee schedule for this program should be made if this phase of the subject were opposed by the government officials.

5. It reviewed and, after amendment, approved the Report of the Committee on State Institutions relative to the utilization of the State Sanatorium for the care of other than tuberculous patients.

6. It continued membership in the Council of the New England State Medical Societies for 1956-1957, and appointed official delegates to this Council.

7. It authorized the president to name Doctor Richard P. Sexton as the Society's official delegate to a meeting of the chairmen of Veterans Affairs Committees to be held in Chicago, January 26-27, and Doctor John T. Barrett to be the Society's delegate to a national conference on polio vaccine distribution called by the American Medical Association for January 26 in Chicago.

8. It authorized the issuance in mimeographed form by the executive office of a list of the more common procedures for which indemnities will be paid under the Dependents Medical Care Program, said list to be sent to the members of the House of Delegates, the Council, and the Secretary of each District Society.

9. It approved of the proposal of the president to submit to the House of Delegates the schedule of prevailing fees proposed by the Fee Study Committee.

10. It appointed a Nominating Committee to prepare a list of candidates for officers and standing committees in 1957-1958.

11. It appointed Doctors Arthur E. Hardy, Charles J. Ashworth, and Samuel Nathans as the Society's representatives on the Rhode Island Joint Commission for the Improvement and Care of the Patient.

12. It authorized the president to meet with representatives of the Rhode Island Osteopathic Society in response to a request for a meeting from that organization.

13. It referred to the Committee on Hospital and Professional Relations the report of the Iowa Medical Society on the hospital-physician controversy in that State.

14. It endorsed uniform claim forms proposed by the Health Insurance Council of the Life Insurance Association of America.

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## HOUSE OF DELEGATES

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15. It authorized legal counsel to attend as the Society's official delegate an American Medical Association regional meeting on medical-legal problems to be held in Philadelphia in March.

16. It voted that the Society award three prizes in the senior high division, and three in the junior high division, of the Rhode Island Science Fair for high school students.

17. It referred to the Committee on Scientific Work and Annual Meeting an invitation to hold the 1958 Annual Meeting in Newport, Rhode Island.

Doctor Thomas Perry read his report of the actions taken by the Council since the last meeting of the House of Delegates, copy of which had been submitted in typed form to each member of the House and is made part of the official minutes of the meeting.

Doctor Charles L. Farrell commented on the report of the Committee on State Institutions and the developments regarding the program for Dependents' Medical Care.

*Action:* It was moved that the report of the secretary be received, approved, and placed on file. The motion was seconded and adopted.

### *Recommendations from the Council*

The secretary reported that the Council offers the following recommendations to the House of Delegates:

1. That the Society's official representatives on the Board of Directors of the Hospital Service Corporation for 1957 be Doctors Charles J. Ashworth and Charles L. Farrell.

*Action:* It was moved that the recommendation be adopted. The motion was seconded and passed.

2. That the date for the 1957 Interim Meeting of the Society be Wednesday, October 23, and that the 1958 Annual Meeting dates be Wednesday, April 30, and Thursday, May 1.

*Action:* It was moved that the recommendation be adopted. The motion was seconded and passed.

### *Annual Report of the Treasurer*

Doctor John A. Dillon reviewed his financial report for 1956 and submitted to each member of the House a summary of the financial statement and he reported that the detailed financial report was available for any delegate to review. He reported that the statement of finances for the year had been carefully reviewed by the Council.

*Action:* It was moved that the Annual Report for 1956 of the treasurer be approved and placed on file. The motion was seconded and adopted.

### *Nominations for Board of Directors of Physicians Service*

The president called to the attention of the House that the by-laws of Physicians Service provided that four members shall be nominated by

the House for three-year terms as members of the Board of Directors of Physicians Service. He noted that the terms expiring as of this date were those of Doctors Rocco Abbate, Frank B. Cutts, Orland F. Smith, and Earl J. Mara.

The secretary reported that he was in receipt of a communication from Doctor Cutts requesting that he not be re-nominated to serve on the Board.

The following members were placed in nomination to serve as members of the Board of Directors of Physicians Service until January, 1960: William J. H. Fischer, Jr., M.D. (Providence); Edmund T. Hackman, M.D. (Kent); Earl J. Mara, M.D. (Pawtucket); and Orland F. Smith, M.D. (Providence).

*Action:* It was moved that the list of nominations be closed. The motion was seconded and adopted.

It was moved that the physicians placed in nomination be the nominees of the House of Delegates to the Corporation of Physicians Service for three-year terms as members of the Board of Directors of the Physicians Service Corporation. The motion was seconded and adopted.

### *Tribute to Directors*

Doctor Charles L. Farrell moved that the House of Delegates add its commendation of Doctors Frank B. Cutts, Rocco Abbate, and Mr. Emil Fachon for their outstanding service to the medical profession as members of the Physicians Service Board of Directors. The motion was seconded and unanimously adopted.

### *Recess*

The House recessed at 8:35 P.M. for the eighth Annual Meeting of the Corporation of the Rhode Island Medical Society Physicians Service and reconvened after the meeting of the Corporation at 9:05 P.M.

* * *

### *Report of National Conference on the Polio Vaccine Program*

Doctor John T. Barrett, chairman of the Child-School Health Committee of the Society and the Society's delegate to a National Conference called by the American Medical Association on January 26 in Chicago, reported on the plans nationally to stimulate interest in polio vaccination for teenagers and adults of all ages. He submitted a summary report of the highlights of the Chicago conference and presented suggested approaches to the problem if the Society decided to participate in it locally.

The entire problem was discussed at length by members of the House of Delegates after which the following policy was adopted:

1. The Society recognizes the importance that all persons in Rhode Island obtain at least

*continued on next page*

two inoculations of Salk Vaccine before the summer of 1957, but feels that it is the responsibility of the individual to avail himself and his family of the opportunity of obtaining the inoculation.

2. The Society, however, through its membership, shares in this responsibility to the extent of making the vaccination available.
3. The Society recommends that the period from February 11 to April 11 be designated for an *All Out-All Ages—Polio Elimination Campaign.*
4. The Society maintains that every physician's office in Rhode Island should be an immunization center and that a concerted effort should be made to get everyone to see his own private physician, or any physician in the Society regardless of his specialty, for the immunizations.
5. The Society recommends that the fee for each polio vaccination including the vaccine, be reduced to $3 during this campaign period from February 11 to April 11, when the visit does not include a general physical examination.
6. The Society contends that where private organizations whether industrial concerns or other groups, purchase vaccine for their members, the inoculations should be performed under the direction of a private physician on a fee for service basis. Physicians employed on a part-time basis as industrial physicians would be considered private physicians for the purpose of this program. Organizations without physicians can contract with a Society physician on a fee for service basis.
7. The Society maintains that the use of public tax funds for either the purchase of vaccine or for the vaccinations, or both, be restricted to those who are unable to pay for the service. The Society urges all health departments to set up plans to cope with this problem.
8. The Society urges all hospitals to inoculate their outpatient cases and their own employees.
9. The Society requests its members to give their complete support to this special polio campaign, and it approves of individual doctors, or groups of doctors, undertaking or participating in mass inoculations during this specified period, with due regard to the policies stated above.

* * *

The House, in approving the report of Doctor Barrett, expressed its commendation for his outstanding work in supervising the polio vaccine distribution during 1956, and for his work in connection with the newly proposed program for adult vaccinations.

* * *

The House moved that the president be authorized to appoint a special committee to supervise for the Society the proposed *All Out-All Ages—Polio Elimination Campaign.* The motion was seconded and adopted.

The president announced that he would appoint Doctor Barrett as chairman of the Committee and would authorize him to suggest the members to serve with him.

* * *

It was moved that the policy regarding this polio program be prepared in letter form and sent to each member of the Society on January 31, and that the release of information to the public regarding the program be made for Friday afternoon, February 1. The motion was seconded and adopted.

### *Fee Schedules*

The president suggested the report of the Committee on Medical Economics, the resolution from the Providence Medical Association relative to the advisability of a state-wide fee schedule, and the report of the special fee committee which initially worked on the schedule for the Dependents' Medical Care program, be considered as a whole.

A copy of the report of the Committee on Medical Economics together with the result of its poll of the component district societies was submitted in mimeographed form to the House and is made part of the official minutes of this meeting. A galley proof of the schedule of fees recommended for possible use for the Society was also submitted in printed form at the request of the president. This schedule based on the work of the special fee committee that reviewed the government's medicare program was submitted in advance of the meeting to each member of the House.

There was lengthy discussion of all phases of the various reports.

*Action:* It was moved to receive the report of the Committee on Medical Economics and place it on file, omitting publication of it other than in the official records of the House of Delegates meeting. The motion was seconded and adopted.

* * *

It was moved and seconded that the schedule of fees as submitted to the House in galley proof form (printed) be accepted as a guide for use by doctors in Rhode Island, and that distribution of it be restricted to one copy to each member of the Society; that the guide be revised annually and that the cover be re-worded to carry out the intention of the House of Delegates. On a division vote the motion was adopted.

### *Air Pollution Abatement Committee*

The report of the Air Pollution Abatement Committee was submitted in mimeographed form to the members of the House in advance of the meeting.

*Action:* It was moved that the report be received and placed on file. The motion was seconded and adopted.

### *Blood Bank*

The report of the Blood Bank Committee was submitted in mimeographed form to the members of the House in advance of the meeting.

*Action:* It was moved that the report be received and placed on file, and that the recommendation be approved. The motion was seconded and adopted.

### *Child-School Health Committee*

The report of the Child-School Health Comittee was submitted in mimeographed form to the members of the House in advance of the meeting.

*Action:* It was moved that the report be received and placed on file. The motion was seconded and adopted.

### *Committee on Chronic Illness*

The report of the Committe on Chronic Illness was submitted in mimeographed form to the members of the House in advance of the meeting.

*Action:* It was moved that the report be received and placed on file. The motion was seconded and adopted.

### *Committee on Federal Medical Service*

The report of the Committee on Federal Medical Service was submitted in mimeographed form to the members of the House in advance of the meeting.

*Action:* It was moved that the report be received and placed on file, and the recommendation approved. The motion was seconded and adopted.

### *Medical Defense and Grievance Committee*

The brief report of the committee submitted in

*continued on next page*

advance to the House was approved and placed on file.

Doctor Francis B. Sargent, chairman of the Committee, discussed the by-law regulation establishing the committee, pointing out that the assignment on a geographical and specialty basis has not proved completely satisfactory. The problem was briefly discussed and it was voted to refer it to the Council for further study. The president discussed the fine work of the Committee on Medical Defense and Grievance and paid tribute to the outstanding service that Doctor Sargent had rendered to the Society as chairman of this very important committee.

### *Highway Safety Committee*

Doctor Arthur E. O'Dea, chairman of the Committee on Highway Safety, reported on the work of his committee relative to possible legislation providing for the use of chemical tests by the Police Departments checking motorists alleged to be driving vehicles while under the influence of narcotics or intoxicating liquors. He submitted to each member of the House a draft of a proposed statute for Rhode Island prepared by the Governor's Highway Safety Council. He reported that the Society's Committee was working closely with the Council on this legislation.

The House also received a report from legal counsel, Mr. Charles P. Williamson, on the proposed amendment to the statute. Several questions were raised regarding the interpretation of the legislation as set forth.

*Action:* It was moved that the House approve in principle the legislation for chemical testing of motorists driving while under the influence of narcotics or intoxicating liquors, and that the Highway Safety Committee of the Society continue its conferences with the legal counsel of the Society and with the Governor's Highway Safety Council to develop the best possible legislation for introduction to the Rhode Island General Assembly. The motion was seconded and adopted.

### *Industrial Health Committee*

The report of the Industrial Health Committee was submitted in mimeographed form to the members of the House in advance of the meeting.

*Action:* It was moved that the report be received and placed on file. The motion was seconded and adopted.

### *Scientific Work and Annual Meeting Committee*

The report of the Committee was submitted in advance of the meeting to the members of the House and was received and placed on file.

### *Committee on Veterans Affairs*

Doctor Richard P. Sexton briefly reported on

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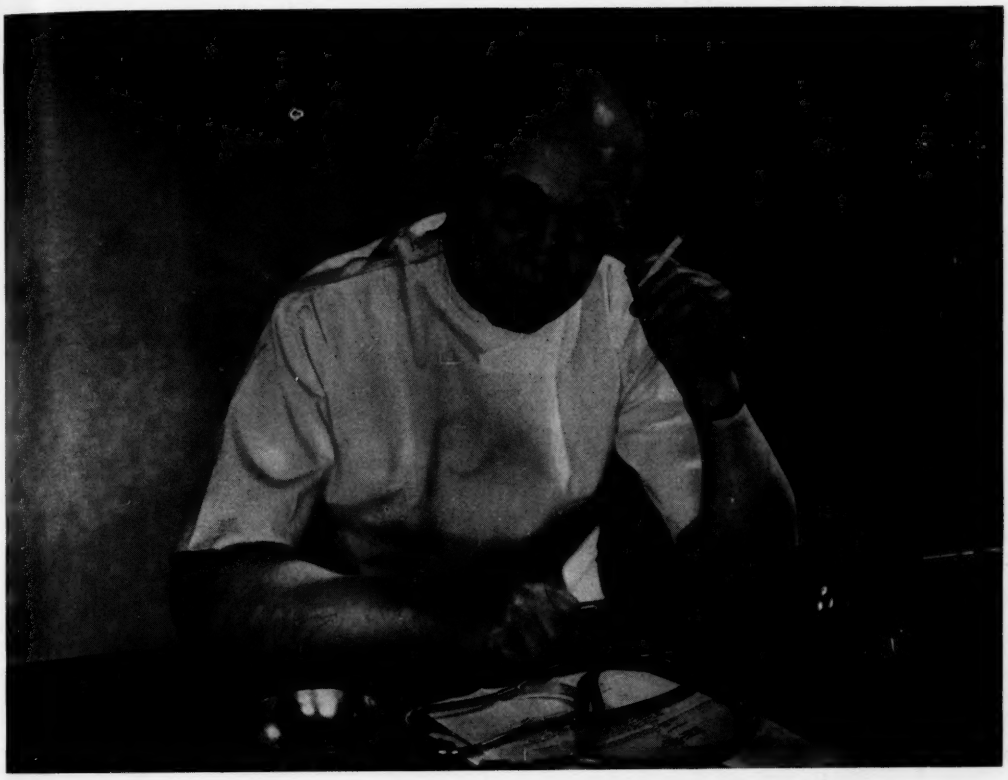

# Who watched his securities today?

The doctor above has spent his day *working*. No one would expect him to take even an hour out of his schedule to devote to his securities. Because today's investment picture is many times more complex than it was even five years ago, he'd need much more time than that in order to do a thorough job.

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If you feel your securities may be suffering, or if you simply want to be relieved of growing financial work, why not talk to one of our trust officers or the manager of your nearest branch office. He'll be glad to explain our services in detail. The fee is moderate, and is deductible from your taxable income.


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## HOUSE OF DELEGATES

*continued from page 188*

the National Meeting held in Chicago in January to discuss problems involving legislation and benefits for veterans of the armed forces.

### *Miscellaneous Business*

### *Kent County Medical Society Resolution*

Doctor Peter Erinakes, delegate from Kent County, submitted to the House of Delegates the following resolution:

*WHEREAS* silver nitrate is the cause of many cases of chemical conjunctivitis in the newborn, the Kent County Medical Society respectfully requests that, first, a study be made to select one or more substitutes for the silver nitrate used prophylactically in the eyes of the newborn, and second, that the matter be referred to the proper committee to affect a change in the law.

*Action:* It was moved to adopt the resolution. The motion was seconded and passed.

It was moved that the President be authorized to appoint a committee consisting of at least one general practitioner, one pediatrician, one obstetrician, and one ophthalmologist to make the study requested by the resolution, and further, that when the committee has completed its report it is authorized to ask the State Department of Health to submit the proper legislation to the Rhode Island General Assembly to carry out its recommendation. The motion was seconded and adopted.

### *Adjournment*

The meeting adjourned at 11:07 P.M.

Respectfully submitted,

THOMAS PERRY, JR., M.D., *Secretary*

## RHODE ISLAND MEDICAL SOCIETY

### Financial Report, 1956

### *Summary*

| | |
|---|---|
| Cash balance, Checking Account, Industrial National Bank, January 1, 1956 | $ 9,719.06 |
| Receipts, 1956 (Exhibit A) | 58,096.22 |
| TOTAL | 67,815.28 |
| Expenses, 1956 (Exhibit B) | 57,858.04 |
| Cash balance, Checking Account, Industrial National Bank, January 1, 1957 | $ 9,957.24 |
| Less | |
| Cash balance, Checking Account, credited to Special Fund of the Society, January 1, 1957 | —242.13 |
| Cash balance, Checking Account, Industrial National Bank, for Operating Expense, January 1, 1957 | $ 9,715.11 |

* * *

| | |
|---|---|
| *Total Cash and Invested Assets, January 1, 1957:* | |
| Cash balance, Checking Account, Industrial National Bank | $ 9,957.24 |
| Investments, Pooled Funds, Trust Dept., Industrial National Bank, and Uninvested Principal Cash | 47,826.00 |
| Suspense Account for Investment— | |
| H. G. Partridge Fund | 1,000.00 |
| General Society Account | 730.86 |
| TOTAL | $59,514.10 |

JOHN A. DILLON, M.D., *Treasurer*

## AIR POLLUTION ABATEMENT COMMITTEE

It came to the attention of the chairman of this committee that the Air Pollution Ordinance in the City of Providence was going to be amended, which in our opinion, might materially weaken the ordinance that is now in effect. Doctor Edward S. Cameron, and also a member of the League of Women Voters of Rhode Island, notified the chairman of this pending action.

The ordinance was reviewed and a letter was sent to the Honorable Walter M. Reynolds, Mayor of Providence, to the effect that great thought should be given before any changes be made in an otherwise excellent piece of legislation. Mayor Reynolds replied stating that any changes would not weaken the structure of this ordinance.

Inasmuch as this Committee did not meet with its members, an individual letter was written to each of the members outlining this piece of business and soliciting the help or thoughts that they might have on the subject.

The Committee has noted with pleasure that the town of East Providence has officially enacted an Air Pollution Abatement Ordinance. This action received support from the committee during the time of its drafting.

FREEMAN B. AGNELLI, M.D., *Chairman*

## BLOOD BANK

The Blood Bank Committee of the Rhode Island Medical Society has met in joint session with the Rhode Island Blood Bank Directors' Association and the Blood Bank Committee of the Rhode Island Hospital Association on several occasions in the past year. Information has been obtained about the blood banks of the state by questionnaires and this information has been tabulated and sent to all

the blood banks in the state. It is hoped that by means of such a study, uniformity of procedures may be developed.

We also have had a meeting to study the Northeast District Clearing House program. Doctor Enold Dahlquist, assistant director of the Rhode Island Hospital blood bank, has attended the organizational meeting, and blood banks of the state are working out arrangements whereby they may participate in the program. By means of this clearing house it is hoped to be able to facilitate the transmittal of credit for blood transfusions in all parts of the country with a minimum of actual shipments of blood and with the arrangements accepted readily by the hospitals of the country. Up to the present, it has been most difficult to ship blood across state lines since so few blood banks have been licensed for interstate shipment. In addition, most hospitals in the past have been reluctant to accept blood from blood banks not known to them; therefore, by means of this clearing program a great step has been made to facilitate an occasionally necessary procedure.

The local telephone exchange program has been in operation for over a year. It is used with varying frequency by member blood banks and efforts are being made to encourage more extensive participation in this program.

The blood bank directors and hospital administrators of the state are working in close conjunction to develop a blood bank program which will fit our needs as they change over the years. It is with this in mind that we have had several meetings and contemplate additional ones in the coming year.

It would be desirable for the composition of the Blood Bank Committee of the Rhode Island Medical Society to consist of the blood bank directors of the state of Rhode Island. They, for the most part, are pathologists who have the proper background for blood bank facilities and who are intimately involved with blood bank operation. In the past, the Blood Bank Committee has been composed of doctors with a varying background insofar as blood banking was concerned. It is for this reason that the two organizations have existed—the Blood Bank Committee of the Medical Society and the Rhode Island Blood Bank Directors' Association. It is recommended that this matter be rectified by the appointment of the medical directors of the blood banks of the state to the Rhode Island Blood Bank Committee of the Rhode Island Medical Society.

HERBERT FANGER, M.D., *Chairman*

### CHILD-SCHOOL HEALTH

The Committee plans to deal with accident prevention and poison control this year with the hope

*continued on next page*

that it can interest Society members to spearhead a drive to familiarize people with the hazards of these major preventable causes of death.

A panel of nationally recognized authorities discussing juvenile delinquency has been suggested as a project for the year. This conference would be directed primarily at professional people and not the laity. It was felt that this might be a joint project of the Rhode Island Medical Society, the American Academy of Pediatrics (Rhode Island Section) and possibly the State of Rhode Island. We recognize that much has been said about this problem but the committee feels that the impetus for doing something might come from professional people.

The Committee has hopes that the membership of the Society, in every possible way they can, will encourage and stimulate the general public, especially up to forty years of age, to be inoculated with poliomyelitis vaccine. The efficacy of the vaccine has been proven and the vaccine is available in quantities that ensure enough for all who wish it. As a corollary to this we feel all members of the Society should themselves to inoculated. What could be more convincing to the public than to learn that the Rhode Island Medical Society members themselves have been protected because of their confidence in the vaccine and because of their respect for poliomyelitis.

JOHN T. BARRETT, M.D., *Chairman*

## CHRONIC ILLNESS

I wish to report that as chairman of the Chronic Illness Committee, I attended a conference on the Health of the Aged, as a delegate of the Rhode Island Medical Society. This was held on December 7, 1956, at the New York Regional Office of the Department of Health, Education and Welfare, 42 Broadway, New York, New York.

At this meeting I met with members of the New England and adjoining state medical societies and discussed primarily what some of the states are doing for the health of the aged and recent developments in the Federal Government regarding this problem. The subjects of rehabilitation, nursing and nutritional problems and preventive medicine in the groups over sixty-five were reviewed.

In the near future I will appoint members of my Committee as representatives of the Society to the Rhode Island Committee on Aging; a Committee group interested in this problem.

RAYMOND E. MOFFITT, M.D., *Chairman*

## FEDERAL MEDICAL SERVICES

The Committee on Legislation of the American Medical Association recently adopted a new legislative program which was approved by the Board of Trustees of that Association.

Under this new program each state society is urged to set up a legislative committee. We have an established Committee on Public Laws, and in addition a Committee on Federal Medical Services.

Of immediate importance to us, however, is the proposal that each state nominate a panel of individuals from whom one or more might be appointed by the American Medical Association's Board of Trustees for a definite term of sufficient duration to insure effectiveness and continuity of service. The individuals involved would be given adequate recognition as an important part of the A.M.A.'s program in each state, and their legislative expenses borne by the Association. These individuals would be responsible to each corresponding regional member of the Committee on Legislation. (Doctor Deering Smith, of Nashua, New Hampshire, is the New England regional member of the A.M.A. Committee on Legislation at this time.)

In the opinion of our Committee one physician, with possibly an alternate, might be named as candidate to the A.M.A. for this new assignment. We recommend for the position Doctor William A. Reid of Providence, who has had legislative experience as a member of the Rhode Island General Assembly.

ARTHUR E. HARDY, M.D., *Chairman*

## MEDICAL DEFENSE AND GRIEVANCE

During the past year the Committee has handled eleven cases of grievance. As no further correspondence was necessary after our findings were reported to the complainants, the Committee assumes that its efforts were successful in each case.

Only three cases of threatened court action came before the Committee in the past twelve months.

FRANCIS B. SARGENT, M.D., *Chairman*

## INDUSTRIAL HEALTH

The Committee on Industrial Health has held several meetings during 1956. Among the major problems considered by the Committee were the

*concluded on page 196*

*new extensive studies[1] show at least*

# 7 advantages

*"over other accepted local applications" in treating wounds and burns*

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tubes of 1 oz., 2 oz., 4 oz., and 1 lb. jars.

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2. serves to protect the wound from mechanical and chemical injury, and from bacterial contamination.
3. helps check infection.
4. "there is no need to sterilize" Desitin Ointment.
5. vitamins A and D plus unsaturated fatty acids of cod liver oil ointment stimulate healthy granulation.
6. it is bland, soothing, non-irritating.
7. healing time shortened, nursing care facilitated.

**samples** and new reprint[1] upon request

**DESITIN CHEMICAL COMPANY**
812 Branch Ave., Providence 4, R. I.

1. Grayzel, H. G., and Schapiro, S.: Western J. Surg., Obstet. & Gynec., Oct. 1956.

# THROUGH . . .  the Microscope

***Equipment Available for Cardiac Patients***

The Rhode Island Heart Association, 100 Lockwood Street, Providence, now has available a limited number of wheel chairs and hospital beds for the home use of cardiac patients, who cannot afford to purchase or rent such equipment for themselves. The equipment will be made available to patients in the light of the following considerations:

(1) That the purchase or rental of such equipment would constitute an economic strain upon the family;
(2) That the family will, except in cases of extreme hardship, plan to meet the cost of trucking of the equipment to the home;
(3) That beds and wheel chairs will be made available for a period of two months, at which time a review of the continued need for such equipment will be made.

The wheel chairs are folding, have adjustable footrests and brakes. The beds are adjustable as to height and have the customary mechanism to elevate knees and head, manually operated.

Applications for the use of this equipment should be accompanied by a statement on the part of the agency concerning the need of the patient and the recommendation of the patient's physician.

***Hospital Bed Total Still Increasing***

As the Health Information Foundation notes that the number of hospital beds in the United States increased 200 per cent from 1909 to 1955, now providing 4.2 beds for every 1,000 persons in the nation, the American Hospital Association, in a January report in its publication, lists a rise in hospital construction work during 1957 to an estimated $775 million. The probable 1946 total for construction costs has been listed as $640 million. Yet, according to Doctor John J. Cronin, assistant surgeon general of the U. S. Public Health Service, author of the article in HOSPITALS, this stepped up construction rate "is not sufficient to eliminate hospital needs in the nation."

A study of the number of hospital beds per 1,000 population by regions for 1955, showed that the New England area ranked fifty of the nine regions, with a 4.2 per cent.

And while all the construction continues unabated the hospital room rates continue to rise. The annual survey of hospital rates by the American Hospital Association indicates that the rates in general hospitals had risen about 6 per cent in the past year.

***R. I. Shares Grant for Mentally Retarded***

Grants to eight states totaling nearly $300,000 for mentally retarded children have been announced by the Children's Bureau of the U. S. Department of Health, Education and Welfare. The Rhode Island project is:

Rhode Island: $17,460 to help finance the first year of a long-range program with special emphasis on infants and preschool children who are mentally retarded. The program will include finding the children, evaluating their abilities, diagnosing their conditions, parent counseling, home training with the help of public health nurses, and work with community agencies in providing needed services for the children. The program will be carried out at the Charles V. Chapin Hospital Outpatient Department in Providence.

The program was started on February 18 at Chapin hospital. Special emphasis is being placed on the medical aspects of retardation. All Rhode Island children on whom a diagnosis of mental retardation is obvious or suspected may be referred to the clinic. Referrals may be sent by a physician, clinic or local health unit acting in the name of a physician. Address inquiries to: Rhode Island Retarded Children's Program, Outpatient Department, Charles V. Chapin Hospital.

***When You Need Clerical Help***

Doctors searching for experienced clerical help will be interested to know that the Professional-Commercial office of the Rhode Island State Employment Service has typists, secretaries and receptionists available to accept positions in physicians' offices.

*concluded on page 196*

### THROUGH THE MICROSCOPE

*concluded from page 194*

These applicants have formerly been employed in hospitals or doctors' offices and desire to remain in the same type of work.

When you register your job orders with the Professional-Commercial Placement office, qualifications of applicants are carefully matched with your job specifications.

The number to call is UNion 1-6200. The address: 130 West Exchange Street, Providence. This placement service is *free of charge*.

### INDUSTRIAL HEALTH

*concluded from page 192*

following:

1. It reviewed the report of the chairman on the Industrial Congress of the American Medical Association, and also the meeting of the Industrial Medical Association.
2. It discussed and endeavored to establish a guide for physical examinations of executives.
3. It proposed a joint meeting with industrial nurses to discuss *Employment Criteria for Industrial Nurses* submitted to the Committee for its approval. When a decision is made on this study, the action of the Committee will be reported to the House of Delegates.
4. It endeavored to activate that part of the Workmen's Compensation Law relating to examinations for back injuries.
5. It noted that the chairman has been named by the Governor as a member for industrial medicine on the Committee on the Employment of the Physically Handicapped.

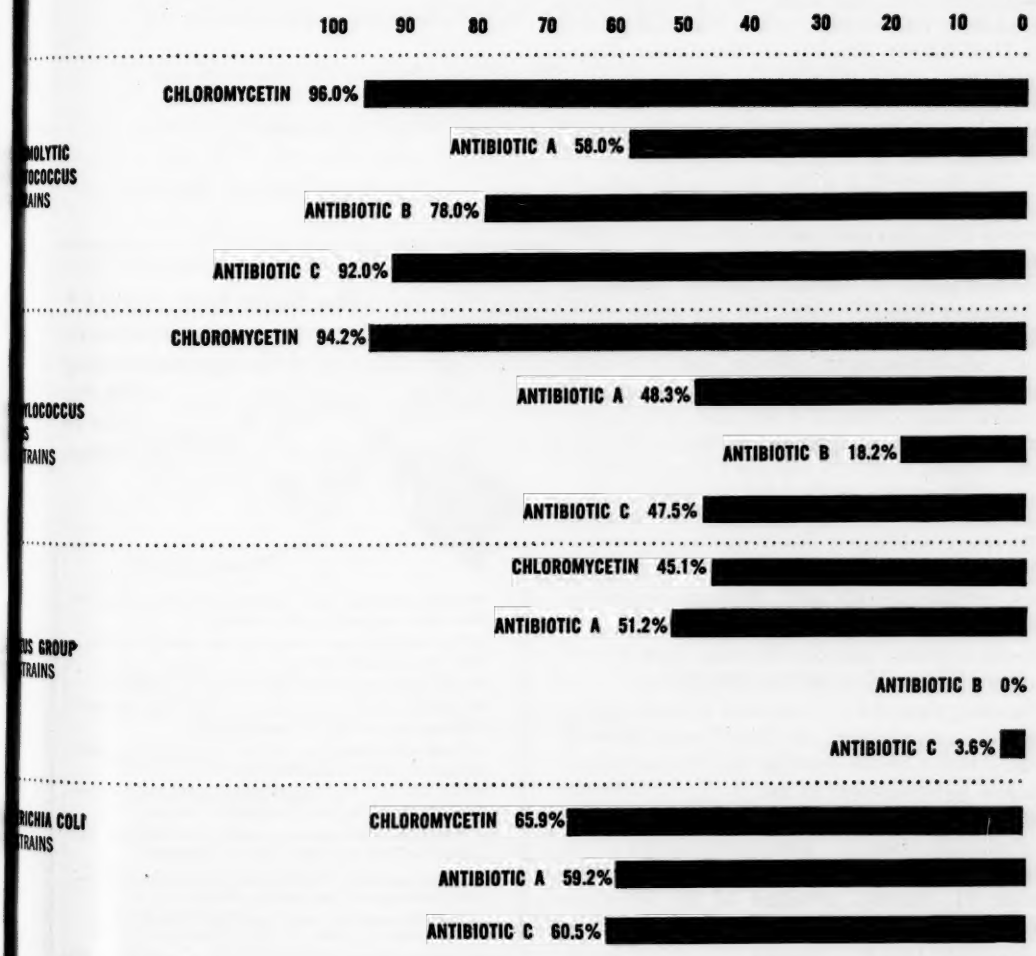
STANLEY SPRAGUE, M.D., *Chairman*

### INDEX OF ADVERTISERS – MARCH

# CTERIAL EFFICACY
# OMYCETIN



## SENSITIVITY OF 4 CLINICALLY IMPORTANT PATHOGENS TO CHLOROMYCETIN AND TO OTHER MAJOR ANTIBIOTIC AGENTS*




*This graph is adapted from Rantz and Rantz.[1] It is based on *in vitro* studies of bacteria freshly isolated from clinical materials.

50109

# THE WOMAN'S AUXILIARY

*Plans for 34th Annual Meeting of Woman's Auxiliary to the A.M.A.*

NEW YORK STATE is serving as host to the American Medical Association and its Woman's Auxiliary, the latter, the parent body of all state and county auxiliaries.

Mrs. Harry F. Pohlmann of Middletown, New York, a past president of the Woman's Auxiliary to the Medical Society of the State of New York, and past chairman of several committees of the A.M.A. Auxiliary, has been named convention chairman for this meeting by the National president, Mrs. Robert Flanders of Manchester, New Hampshire.

Headquarters for the Auxiliary's meeting will be the Hotel Roosevelt at Madison Avenue and 45th Street, New York City, from June 3 to 7, 1957. The Roosevelt is within walking distance of the Waldorf-Astoria Hotel, where the A.M.A.'s House of Delegates meet, and in proximity to Fifth Ave. and Madison Ave. shops, theaters and innumerable points of interest make the location of headquarters ideal.

Registration will open on Sunday, June 2 at 11:30 A.M., continuing to 4:00 P.M., and all through Thursday. On Monday, June 3, and Wednesday afternoon, June 5, there will be round-table discussions of interest and educational value to all physicians' wives. Members and guests are cordially invited. The general meeting will be held Tuesday, Wednesday, and Thursday until noon, and a Board of Directors' meeting at one o'clock on Thursday, and a Post-Convention Workshop for state presidents, presidents-elect and National committee chairmen on Friday, June 7.

*Social activities* include: Monday, June 3 — a tea, honoring president and president-elect.

*Tuesday, June 4th — Luncheon* in honor of the National past presidents, at which Doctor Howard Rusk, director of the Institute of Physical Medicine and Rehabilitation of the N. Y. U. Bellevue Medical Center, will be the guest speaker.

*Wednesday, June 5 — Luncheon* in honor of the National president and president-elect. Doctor Dwight H. Murray, president of the American Medical Association, will be the guest speaker.

*Thursday, June 6 — Annual Dinner* for Auxiliary members, husbands and guests, at which the guest speaker will be Professor Allen Richard Foley of Dartmouth College.

It is hoped that each state and county Auxiliary and the territorial Auxiliaries will be well represented. A warm welcome awaits everyone, and a profitable meeting and many hours of pleasure will make your visit a memorable one.

***Save Saturday, October 19***

**Annual Auxiliary Dance**

**at the**

**Sheraton-Biltmore Hotel**